S. Hrg. 100-368, Pt. 1

# CLINICAL STAFFING RECRUITMENT AND RETENTION PROGRAM—PART I

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## HEARING

BEFORE THE

## SELECT COMMITTEE ON INDIAN AFFAIRS
## UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

## S. 1475

TO ESTABLISH AN EFFECTIVE CLINICAL STAFFING RECRUITMENT AND RETENTION PROGRAM, AND FOR OTHER PURPOSES

AUGUST 6, 1987
WASHINGTON, DC

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# CLINICAL STAFFING RECRUITMENT AND RETENTION PROGRAM

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THURSDAY, AUGUST 6, 1987

U.S. Senate,
Select Committee on Indian Affairs,
*Washington, DC.*

The committee met, pursuant to notice, at 2:05 p.m., in room 485, Russell Senate Office Building, Hon. Daniel K. Inouye (chairman of the committee) presiding.

Present: Senators Inouye, Melcher, Evans, DeConcini, and McCain.

## STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII, CHAIRMAN, SELECT COMMITTEE ON INDIAN AFFAIRS

The Chairman. The hearing will please come to order.

This afternoon we take up S. 1475, a bill introduced by the distinguished Senator from Montana, Senator Melcher. It is a bill to establish an effective clinical staffing recruitment and retention program for the Indian Health Service.

A special report prepared by the Office of Technology Assessment in February of this year, entitled, Clinical Staffing in the Indian Health Service, indicates that after 1988, which is a year from now, the rapid decline of physicians will severely limit the ability of the Indian Health Service to deliver health care to American Indians and Alaska Natives. And with the termination of the National Health Service Corps Scholarship Program, a major source of physician supply for the Indian Health Service, this situation can be expected to worsen.

S. 1475, introduced by Senator John Melcher, seeks to address the problems of the health care professional shortages in the IHS by providing first, a loan repayment program which will authorize the IHS to recruit health professionals and secure written contracts for the repayment of student loans up to $25,000 per year in exchange for each year of obligated service. Second, a program for enhanced recruitment including payment for spouse travel, expansion of the Indians into Medicine Program, retention bonuses, continuing education opportunities; and third, educational programs on tribal history and culture for IHS personnel.

The bill also provides for the establishment of an advisory panel of health professionals to review and report on policies and procedures which may impede recruitment and retention.

[The text of S. 721 follows:]

II

100TH CONGRESS
1ST SESSION

To establish an effective clinical staffing recruitment and retention program, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

JULY 9 (legislative day, JUNE 23), 1987

Mr. MELCHER (for himself, Mr. INOUYE, and Mr. BURDICK) introduced the following bill; which was read twice and referred to the Committee on Indian Affairs

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# A BILL

To establish an effective clinical staffing recruitment and retention program, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

## TITLE I—LOAN REPAYMENT PROGRAM

### INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM

SEC. 101. (a) The Secretary, acting through the Service, shall establish a program to be known as the Indian Health Service Loan Repayment Program (hereafter in this Act referred to as the "Loan Repayment Program") in order to assure an adequate supply of trained physicians, dentists, and nurses for the Service (and for health facilities and health programs maintained by any Indian tribe, tribal organization, or urban Indian organization under a contract entered into with the Secretary) and, if needed by the Service or by such Indian tribe, tribal organization, or urban Indian organization, podiatrists, optometrists, pharmacists, clinical and counseling psychologists, graduates of schools of public health, graduates of schools of social work, graduates of programs in health administration, graduates of programs for the training of physicians assistants, expanded function dental auxiliaries, nurse practitioner (within the meaning of section 822 of the Public Health Service Act (42 U.S.C. 296m)), and other health professionals.

(b) To be eligible to participate in the Loan Repayment Program, an individual must—

(1) be enrolled as a full-time student and in the final year of a course of study or program in an accredited (as determined by the Secretary) educational institution in a State which is approved by the Secretary pursuant to the provisions of this title; or

(2) in a graduate training program in a course of study approved by the Secretary pursuant to the provisions of this title; or

(3) have a degree in medicine or other health profession which is approved by the Secretary pursuant to the provisions of this title.

(c) An individual applying for the Loan Repayment Program must be eligible for, or hold, an appointment as a commissioned officer in the Service or be eligible for selection for civilian employment by the Service.

(d) An applicant for the Loan Repayment Program must submit an application to participate in the Loan Repayment Program, and must sign and submit to the Secretary, at the time of the submission of such application, a written contract (described in subsection (h)) to accept repayment of educational loans and to serve (in accordance with this subtitle) for the applicable period of obligated service in the Indian Health Service.

(e) In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under section 104 in the case of the individual's breach of the contract.

(f)(1) The Secretary shall only approve applications under the Loan Repayment Program that are made by individuals whose training is in a health profession or specialty determined by the Secretary to be needed by the Service.

(2) In determining which applications under the Loan Repayment Program to approve, the Secretary shall extend a preference to Indians.

(g)(1) An individual becomes a participant in the Loan Repayment Program only upon the Secretary's approval of the individual's application submitted under subsection (c) and the Secretary's acceptance of the contract submitted by the individual under subsection (c).

(2) The Secretary shall provide written notice to an individual promptly upon the Secretary's approving, under paragraph (1), of the individual's participation in the Loan Repayment Program.

(h)(1) In the written contract referred to in this subtitle between the Secretary and an individual, the Secretary shall agree to—

(a) pay loans in behalf of the individual in accordance with the provisions of this title, and accept the individual into the Service.

(b) In the written contract (referred to in this subtitle), the individual shall agree to—

(1) accept loan payments for the purposes described in this title; and

(2) in the case of an individual who is enrolled in an accredited institution as a full-time

student or in a graduate training program, the individual shall agree to—

(A) maintain enrollment in the course of study until the individual completes the course of study or training; and

(B) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training); and

(C) to provide certification to the Secretary of the degree or diploma awarded to the individual in the health profession approved by the Secretary; and

(D) to serve for a time period (hereafter in this title referred to as the "period of obligated service" equal to 2 years or such longer period as the individual may agree to serve in a health program maintained by—

(i) the Service, or

(ii) any Indian tribe, tribal organization, or urban Indian organization under a contract entered into with the Secretary, to which the individual is assigned by the Secretary;

(2) a provision that any financial obligation of the United States arising out of a contract entered into under this subtitle and any obligation of the individual which is conditioned thereon, is contingent upon funds being appropriated for loan repayments under this subtitle and to carry out the purposes of this subtitle;

(3) a statement of the damages to which the United States is entitled, under section 104 for the individual's breach of the contract; and

(4) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with the provisions of this subtitle.

(j)(1) A loan repayment provided for an individual under a written contract under the Loan Repayment Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual for—

(A) tuition expenses;

(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; or

(C) reasonable living expenses as determined by the Secretary.

(2) For each year of obligated service that an individual contracts under subsection (f) to serve, the Secretary may pay up to $25,000 on behalf of the individual for loans described in paragraph (1).

(k) Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section, while undergoing academic training, shall not be counted against any employment ceiling affecting the Department.

(l) The Secretary shall, by not later than March 1 of each year, submit to the Congress a report providing—

(1) the number, and type of health profession training, of individuals receiving loan payments under the Loan Repayment Program;

(2) the educational institution at which such individuals are receiving their training or have completed their training;

(3) the total number of applications filed under this section during the preceding year;

(4) the number of such applications filed with respect to each type of health profession;

(5) the total number of contracts described in subsection (f) that are entered into during the preceding year;

(6) the number of such contracts entered into during the preceding year with respect to each type of health profession; and

(7) the amount of loan payments made in the preceding year.

### RECRUITMENT

SEC. 102. (a) The Secretary may conduct at schools of medicine, osteopathy, dentistry, and, as appropriate, nursing and other schools of the health professions and at entities which train allied health personnel, recruiting programs for the Loan Repayment Program.

(b) Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

### OBLIGATED SERVICE UNDER CONTRACT

SEC. 103. (a) Each individual who has entered into a written contract with the Secretary under section 101 shall provide service in the full-time clinical practice of such individual's profession in the Indian Health Service for the period of obligated service provided in such contract.

(b)(1) If an individual is required under subsection (a) of this section to provide obligated service, the Secretary shall, not later than 90 days before the date described in paragraph

(4), determine if the individual shall provide such service as a commissioned officer in the Regular or Reserve Corps of the Public Health Service or as a civilian employee of the Indian Health Service, and shall notify such individual of such determination.

(2) If the Secretary determines that an individual shall provide obligated service to the Indian Health Service as a commissioned officer in the Public Health Service or a civilian employee of the Indian Health Service, the Secretary shall, not later than 60 days before the date described in paragraph (4), provide such individual with sufficient information regarding the advantages and disadvantages of service as such a commissioned officer or civilian employee to enable the individual to make a decision on an informed basis. To be eligible to provide such obligated service as a commissioned officer in the Public Health Service, an individual shall notify the Secretary, not later than 30 days before the date described in paragraph (4), of the individual's desire to provide such service as such an officer. If an individual qualifies for an appointment as such an officer, the Secretary shall, as soon as possible after the date described in paragraph (4), appoint the individual as a commissioned officer of the Regular or Reserve Corps of the Public Health Service.

(3) If an individual provided notice by the Secretary under paragraph (2) does not qualify for appointment as a

commissioned officer in the Public Health Service, the Secretary shall, as soon as possible after the date described in paragraph (4), appoint such individual as a civilian employee of the Indian Health Service.

(4)(A) With respect to an individual receiving a degree from a school of medicine, osteopathy, psychology, or dentistry, the date referred to in paragraphs (1) through (3) shall be the date upon which the individual completes the training required for such degree, except that the Secretary shall, at the request of such individual, defer such date until the end of the period of time (not to exceed 3 years or such greater period as the Secretary, consistent with the needs of the Service, may authorize) required for the individual to complete an internship, residency, or other advanced clinical training. With respect to an individual receiving a degree from a school of optometry, podiatry, or pharmacy, the date referred to in paragraphs (1) through (3) shall be the date upon which the individual completes the training required for such degree, except that the Secretary shall, at the request of such individual, defer such date until the end of the period of time (not to exceed 1 year or such greater period as the Secretary, consistent with the needs of the Service, may authorize) required for the individual to complete an internship, residency, or other advanced clinical training. No period of internship, residency, or other advanced clinical training shall be counted toward satisfying a period of obligated service under this subtitle.

(B) With respect to an individual receiving a degree from an institution other than a school referred to in subparagraph (A), the date referred to in paragraphs (1) through (3) shall be the date upon which the individual completes his academic training leading to such degree.

(C) With respect to an individual who has received a degree in medicine, osteopathy, psychology, dentistry, or other health profession and has completed graduate training, the date referred to in paragraphs (1) through (3) shall be the date on which the individual enters into a contract with the Secretary under section 101.

(c) An individual shall be considered to have begun serving the period of obligated service on the date such individual is appointed as an officer in a Regular or Reserve Corps of the Public Health Service under subsection (b)(2) or is appointed as a civilian employee of the Indian Health Service under subsection (b)(3).

### BREACH OF CONTRACT

SEC. 104. (a) An individual who has entered into a written contract with the Secretary under section 101 and who—

(1) is enrolled in the final year of a course of study and fails to maintain an acceptable level of academic standing in the educational institution in which the individual is enrolled (such level determined by the

educational institution under regulations of the Secretary) or voluntarily terminates such enrollment or is dismissed from such educational institution before completion of such course of study, or

(B) is enrolled in a graduate training program, fails to complete such training program,

in lieu of any service obligation arising under such contract shall be liable to the United States for the amount which has been paid on his behalf under the contract.

(b) If (for any reason not specified in subsection (a)) an individual breaches his written contract under section 101 by failing either to begin such individual's period of obligated service in accordance with section 103 or to complete such period of obligated service, the United States shall be entitled to recover from the individual an amount determined in accordance with the following formula:

$$A=2z\left(\frac{t-s}{t}\right)$$

in which 'A' is the amount the United States is entitled to recover, 'z' is the sum of the amounts paid under this subtitle to, or on behalf of, the individual and the interest on such amounts which would be payable if at the time the amounts were paid they were loans bearing interest at the maximum legal prevailing rate, as determined by the Treasurer of the United States, 't' is the total number of months in the individual's period of obligated service, and 's' is the number of months of such period served by him in accordance with section 103 of this title. Any amount of damages which the United States is entitled to recover under this subsection shall, within the 1-year period beginning on the date of the breach of the written contract (or such longer period beginning on such date as specified by the Secretary for good cause shown), be paid to the United States.

(c)(1) Any obligation of an individual under the Loan Repayment Program (or a contract thereunder) for service or payment of damages shall be canceled upon the death of the individual.

(2) The Secretary shall by regulation provide for the partial or total waiver or suspension of any obligation of service or payment by an individual under the Loan Repayment Program (or a contract thereunder) whenever compliance by the individual is impossible or would involve extreme hardship to the individual and if enforcement of such obligation with respect to any individual would be unconscionable.

(3) Any obligation of an individual under the Loan Repayment Program (or a contract thereunder) for payment of damages may be released by a discharge in bankruptcy only if such discharge is granted after the expiration of the 5-year period beginning on the first date that payment of such damages is required.

### REPORTS

SEC. 105. The Secretary shall submit to the Congress on July 1 of 1988, and of each succeeding year, a report on the number of providers of health care who will be needed for the Indian Health Service during the 3 fiscal years beginning after the date the report is filed and—

(1) the number of scholarships, if any, the Secretary proposes to provide under the National Health Service Corps Scholarship Program during such 3 fiscal years, and

(2) the number of individuals for whom the Secretary proposes to make loan repayments under the Loan Repayment Program during such 3 fiscal years.

### AUTHORIZATION FOR APPROPRIATIONS

SEC. 106. There are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the provisions of this title.

## TITLE II—OTHER RECRUITMENT AND RETENTION PROVISIONS

### TRAVEL EXPENSES FOR RECRUITMENT

SEC. 201. (a) The Secretary may reimburse health professionals seeking positions in the Service (including individuals considering entering into a contract under section 101) and their spouses for actual and reasonable expenses incurred in traveling to and from their places of residence to an area in which they may be assigned for the purpose of evaluating such area with regard to being assigned in such area.

(b) There are authorized to be appropriated for each fiscal year $100,000 for the purpose of carrying out the provisions of this section.

### TRIBAL DEMONSTRATION RECRUITMENT AND RETENTION PROGRAM

SEC. 202. (a) The Secretary, acting through the Service, shall award grants to Indian tribes and tribal organizations for the purpose of enabling the Indian tribes and tribal organizations to develop and test, in cooperation with the Service, innovative techniques to recruit, place, and retain health professionals.

(b) The Secretary shall prescribe such regulations as are necessary to carry out the provisions of this section.

(c) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

### TRIBAL CULTURE AND HISTORY

SEC. 203. (a) The Secretary, acting through the Service, shall establish a program under which all employees of the Service who serve particular Indian tribes shall receive educational instruction in the history and culture of such tribes and in the history of the Service.

(b) To the extent feasible, the program established under subsection (a) shall—

(1) be carried out through tribally-controlled community colleges, and

(2) be developed in consultation with the affected tribal government, and

(3) include instruction in Native American studies.

(c) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

### INMED PROGRAM

SEC. 204. (a) The Secretary is authorized to provide grants to colleges and universities for the purpose of maintaining and expanding the Native American health careers recruitment program known as the "Indians into Medicine Program" (hereinafter in this section referred to as "INMED") as a means of encouraging Indians to enter the health professions.

(b) In addition to maintaining the INMED program at the University of North Dakota, the Secretary shall provide grants to at least two additional universities or colleges for the purpose of expanding the INMED program model.

(c) The Secretary shall develop regulations for the competitive awarding of the grants established in this section provided that the universities applying for such funds agree to provide a program which—

(1) provides outreach and recruitment for health professions to Native American communities including

elementary, secondary and community colleges located on Indian reservations which will be served by the program,

(2) incorporates a program advisory board comprised of representatives from the tribes and communities which will be served by the program,

(3) provides summer preparatory programs for Native American students who need enrichment in the subjects of math and science in order to pursue training in the health professions,

(4) provides tutoring, counseling and support to students who are enrolled in a health career program of study at the respective college or university, and

(5) to the maximum extent feasible agree to employ qualified Native American staff for the program.

(d) By no later than the date that is 3 years after the date of enactment of this Act, the Secretary shall submit a report to Congress on the program including recommendations for expansion or changes to the program.

(e) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

### ADVANCED TRAINING AND RESEARCH

SEC. 205. (a) The Secretary, acting through the Service, shall establish a program to enable health professionals who have worked for the Service for a substantial period of time to pursue advanced training or research at medical schools, or other professional schools or facilities, in areas of study for which the Secretary determines a need exists.

(b) The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section.

ADDITIONAL INCENTIVES FOR HEALTH PROFESSIONALS

SEC. 206. (a) The Secretary shall provide the incentive special pay authorized under section 302(b) of title 37, United States Code, by reason of section 208(a) of the Public Health Service Act (42 U.S.C. 210(a)), to—

(1) commissioned medical officers of the Regular and Reserve Corps of the Public Health Service who are assigned to positions for which recruitment or retention of personnel is difficult in the Indian Health Service, and

(2) civilian medical officers of the Service who are assigned to positions for which recruitment or retention of personnel is difficult.

(b) The Secretary shall establish and update on an annual basis a list of positions (other than medical officers) of health care professionals employed by or assigned to the Service for which recruitment or retention is difficult.

(2)(A) The Secretary shall pay a bonus to any person who is employed in or assigned to, a position in the Service included in the list established by the Secretary under paragraph (1)(b).

(B) The Secretary may not exceed $2,000 in total bonus payments made under this section to any employee within any 1-year period.

(c) The Secretary shall establish programs to allow the use of flexible work schedules, and compressed work schedules, in accordance with the provisions of subchapter II of chapter 61 of title 5, United States Code, for health professionals employed by, or assigned to, the Service.

(d) Notwithstanding any provision of law, no limitation imposed on amounts of premium pay paid for overtime shall apply to any individual employed by, or assigned to, the Service. The rate of overtime pay for such individual shall be computed as provided in section 5542 of title 5, United States Code.

### RETENTION BONUS

SEC. 207. (a) The Secretary shall pay a retention bonus to medical officers employed by or assigned to the Service either as a civilian employee or member of the Commisson Corps who—

(1) has satisfied one of the following criteria:

(A) has completed three years of employment with the Service; or

(B) has completed any service obligation incurred as a result of—

(i) acceptance of any Federal scholarship program; or

(ii) any Federal education loan repayment program.

(b) enters into an agreement with the Service for continued employment for a period of not less than 1 year.

(c) The Secretary shall establish specific rates for the retention bonus which shall provide for a higher annual rate for multi-year agreements than for single year agreements but in no event shall the annual rate be less than $12,000 per annum nor shall the annual rate be more than $25,000 per annum.

(d) The retention bonus for the entire period covered by the agreement in paragraph (2) shall be paid at the beginning of the agreed upon term of service.

(e) Any physician failing to complete the agreed upon term of service, except where such failure is through no fault of the individual, shall be obligated to refund to the government the full amount of the retention bonus for the period covered by the agreement plus interest as determined by the Secretary after consultation with the Secretary of the Treasury.

### FOREIGN MEDICAL GRADUATE DEMONSTRATION PROJECT

SEC. 208. (a) The Secretary shall establish a 3-year demonstration project in the Indian Health Service which utilizes foreign medical graduates to assist in the delivery of health care in IHS hospital facilities.

(b) The Secretary shall conduct the demonstration project at not less than 2 IHS hospitals which have the staff capability to provide orientation, training, and supervision to the foreign medical graduates selected to participate in the demonstration project.

(c) The Secretary shall develop a program which provides orientation, training, and supervision to the participants in the demonstration project which—

(1) assesses the abilities of each foreign medical graduate participating in the demonstration project,

(2) provides individualized orientation and training to each participant,

(3) provides individualized work assignments based upon the individual's training, experience and capabilities, and which are under the supervision of an IHS medical officer, and

(4) prepares each participant to obtain a license as a physician assistant.

(c) The Secretary shall select at least 10 individuals to participate in the demonstration project who satisfy the following criteria—

(1) had been licensed to practice medicine in his or her country of origin;

(2) had practiced medicine in his or her country of origin for at least 5 continuous years;

(3) are proficient in the oral and written use of the English language;

(4) have obtained citizenship or status of permanent residents of the United States; and

(5) originate from countries which are friendly with or allied with the United States.

(d) By the date that is no later than 3 years after enactment of this Act, the Secretary shall submit a report to Congress on the demonstration project which shall include recommendations for maintaining and expanding the demonstration project as a means of enabling the Service to more effectively deliver health care.

(e) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section.

## REPORT ON RECRUITMENT AND RETENTION

SEC. 209. (a) The Secretary of Health and Human Services shall establish an advisory panel composed of—

(1) 10 physicians or other health professionals who are employees of, or assigned to, the Indian Health Service,

(2) 3 representatives of tribal health boards, and

(3) 1 representative of an urban health care organization

for the purpose of conducting an investigation of administrative policies and regulatory procedures which impede the recruitment or retention of physicians and other health professionals by the Indian Health Service.

(b) By no later than the date that is 18 months after the date of enactment of this Act, the advisory panel established under subsection (a) shall submit to the Congress a report on the investigation conducted under subsection (a), together with any recommendations for administrative or legislative changes in existing law, practices, or procedures.

### EARLY RETIREMENT

SEC. 210. Section 8336(j)(1)(B) of title 5, United States Code, is amended by striking out "December 21, 1972" and inserting in lieu thereof "December 5, 1979."

### DEFINITIONS

SEC. 212. For purposes of this Act—

(a) The term "the Secretary" means the Secretary of Health and Human Services.

(b) The term "the Service" means the Indian Health Service of the Department of Health and Human Services.

(c) The term "Indian", "Indian tribe", "tribal organization", and "urban Indian organization" have the respective meanings given to such terms by section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

○

The **Chairman**. Senator Melcher, I am certain you would like to make an opening statement.

## STATEMENT OF HON. JOHN MELCHER, U.S. SENATOR FROM MONTANA

Senator **Melcher**. Thank you very much, Mr. Chairman, and thank you very much for scheduling this hearing. I really welcome this opportunity to have the hearing on S. 1475.

We're facing a very tough situation right now in Indian Health Service, without a sufficient supply of physicians and nurses and lab technicians. And unless steps are taken to correct that situation, and turn it around, we see a tough situation deteriorating into a very serious crisis.

I believe that it's a trust responsibility of the Federal Government to provide health care, clinical facilities, hospital facilities for Indian people. And unless those facilities and health care continue, there's a million American Indians where their health is indeed at risk. I hope we can pass a bill very quickly. The bill does provide for incentives and increases in pay being basic for that, but also the opportunity to have decent living conditions and living situations for the families of the health care professionals. That's also given some encouragement in the bill.

If we can pass a bill this Fall, perhaps we can turn the tide and instead of a declining number of physicians and nurses and lab technicians, we'll first of all, hold what we've got, and add to it with recruitment after that.

Thanks again, Mr. Chairman, for having this hearing, and for your co-sponsorship of the bill, which is extremely important, and for your continuous efforts to help Indians on health matters, as well as other matters.

[Prepared statement of Senator Melcher appears in the appendix.]

The **Chairman**. Thank you very much.

I would like to call upon the distinguished Vice Chairman of this committee.

## STATEMENT OF DANIEL J. EVANS, U.S. SENATOR FROM WASHINGTON, VICE CHAIRMAN, SELECT COMMITTEE ON INDIAN AFFAIRS

Senator **Evans**. Thank you, Mr. Chairman.

I'm particularly interested in this legislation. I think of all of the legislation we have had before us this year, this could rank among the very most important. I'm certain we need to develop both immediate and long range solutions to the problems of clinical staff shortages.

I'm sure you're aware, Mr. Chairman, vividly, that American Indians have a lower health status than the general U.S. population, and unfortunately the primary resources provided to improve or to elevate that Indian health, are terribly low. This hearing is an important step toward finding out the resources, the programs and the solutions needed to address these problems.

I commend Senator Melcher in his efforts for resolving the issue. You could say at the outset, Mr. Chairman, that I have some reservations about lack of long term methods for addressing the problems, and legislation, I hope, will focus on a comprehensive approach. A comprehensive approach which considers the community needs of Indian people, and derives much from their ideas and their counsel with us. I am hopeful, and I do believe that there are solutions to these problems, and look forward to this hearing, where I am sure the witnesses will describe for us the obstacles, and hopefully, some of the solutions for improving the recruitment and retention of health professionals in the Indian Health Service.

The CHAIRMAN. I thank you very much.

Senator McCain.

Senator McCAIN. No thank you, Mr. Chairman.

The CHAIRMAN. Senator DeConcini.

Senator DECONCINI. Mr. Chairman, thank you.

I have no prepared statement, but I'm interested in the subject matter, and compliment Senator Melcher for his leadership in introducing this and you holding the hearings on it. I think there is a great need there, and I'm certainly interested in the details of the legislation, and how do we finance it. To me, as Senator Melcher said, there is an obligation and responsibility for Government to provide the adequate health personnel, which we certainly have not done. So I thank the Chairman for the hearings today.

The CHAIRMAN. Thank you much.

I agree with all of you that if nothing is done about the present situation, we may be faced with a real crisis a few years down the road. I have seen statistics that would suggest that we have surplus of physicians in the United States, and this surplus will grow. However, to expect this surplus to move into reservations, may not be pragmatic or realistic.

I would think the surplus doctors, as I told some of my friends, would prefer to serve in San Francisco, than on the Navajo Reservation. What we have to do is to provide these doctors with certain incentives. And this bill, I believe, will provide some of these.

Our first panel consists of Ms. Ellen Smith, Analyst, Office of Technology Assessment, and Dr. Emery Johnson, former Director of Indian Health Service, of Rockville, Maryland.

Dr. Johnson, Ms. Smith will you come forward?

Welcome Ms. Smith.

Ms. SMITH. Thank you.

The CHAIRMAN. It is because of your report that we are here.

## STATEMENT OF ELLEN SMITH, ANALYST, OFFICE OF TECHNOLOGY ASSESSMENT, WASHINGTON, DC

Ms. SMITH. I worked on the larger study of Indian Health Care, the one that was published in April 1986 by the Office of Technology Assessment, and also on the follow-up study of clinical staffing, which is the report that I'll be talking about today.

As you pointed out, it has become apparent that there will be—that there already are—shortages of staff in the Indian Health Service, and that because of the Indian Health Service's dependence on the National Health Service Corps for its new recruits, the shortage is likely to become much more serious very soon. It will be 1988 and thereafter. So we're talking about an immediate problem.

I'll try to summarize my testimony here. As you know, IHS operates both a direct care delivery system, and also a contract health care system. The contract care system is designed to purchase services that are not available from the Indian Health Service from the private sector. This program has been limited in the past by its budget, and in fact, services from the contract care program are frequently rationed.

The direct care program of hospitals and clinics is staffed by approximately 10,400 individuals, about 750 physicians and 2,800 nurses. Different sources that I reviewed for this study indicated that the current staffing, this 10,400 level, probably is about 10 to 20 percent short of what IHS would need or would want to have to deliver the level of services they're providing now. Again, budget constraints are a factor in this because nearly 10 percent of the staff positions, about 1,100 positions, are vacant at any given time, not throughout the entire year, due to lack of funding. These are called the recurring vacancies.

The CHAIRMAN. Can you repeat that again, 1,100 physicians?

Ms. SMITH. About 1,100 positions, not physicians, total people, out of the 10,400.

One of the reasons for this problem is that IHS has difficulty retaining the physicians that work for IHS. The majority of them, now 45 percent probably, are in the National Health Service Corps, which means that when they're done with their obligated service, they're no longer obliged to serve in the Indian Health Service. And, in fact, only about five percent of those physicians will stay even one more year. Even of the voluntary physicians that are recruited, not many more than 5 percent will remain after their first 2-year assignment. So retention is a very serious problem in maintaining the staffing level of physicians. In fact, IHS estimates that it needs to replace about 200 physicians out of this 750 or 800 every year. So, that's a major problem.

My study did not address nurse staffing as much, but recruiting an adequate number of nurses also is a very severe problem, especially in some areas. And you probably know that nursing as a profession is not growing at this time, and so nurse staffing also will become a more serious problem.

There are some tables attached to the testimony that show the availability of National Health Service Corps physicians to the Indian Health Service. They indicate that after 1988, there will be very few physicians available, and the number that will be available will not be only for the Indian Health Service, but will also be needed to staff community health centers, Federal prisons, and other Federal facilities.

The reason that the National Health Service Corps will have very few physicians is that the program is gradually being phased out. Since 1980 there have been very few new scholarship awards, so that as of the last information I had in 1986, there were only about 50 National Health Service Corps scholarships funded. So this is why the source has dried up.

The justification for phasing out the program is that to be a surplus of physicians is expected in the United States in the near future. There is some debate and some questions about this assumption. But even if there were to be more physicians who were relocating to rural areas, it would not necessarily help the Indian Health Service, because in order for those physicians to serve Indian patients, they would have to be employed by the Indian Health Service. That means the Indian Health Service has to recruit them, which means that the Indian Health Service has to pay for them. The Indian Health Service can offer a three-year resident family practice physician only about $45,000 a year to start. Many rural communities can do better than that. So the surplus is not necessarily going to solve the problem.

One other point that I want to make is about the Public Health Service Commissioned Corps, which has always been a major factor in the Indian Health Service. The Commissioned Corps has provided services for many years on the reservations. They represent about 20 percent of the total IHS work force, but about 80 percent of IHS physicians are in the Commissioned Corps. So any changes in the Commission Corps, obviously, could have a major effect on the Indian Health Service, and on its physician staffing. As you know, the Surgeon General has talked about a plan to revitalize the Commissioned Corps. I personally am not entirely familiar with that plan, but, obviously, it's something that the Indian Health Service would need to keep track of to see what the effects might be.

There has been some criticism of the Commissioned Corps. It has been argued that the Corps is anachronistic and it's too expensive. But for example, the Navajo area compared their actual costs of using civil service physicians with the cost of using Commissioned Corps physicians, and found that because of the need to pay overtime for civil service, Commissioned Corps physicians actually were less expensive to use in the Navajo area, and probably in other areas as well, than the civil service.

I bring this up because of the provision in Senate Bill 1475 that would eliminate the cap on overtime pay for civil service physicians. This is my personal opinion, but I would just urge that that provision be carefully considered. Even with the cap on civil service overtime pay, civil service physicians in the field can earn up to $69,000 a year, whereas Commissioned Corps physicians make maybe $45,000 on an average. If you remove the cap on overtime pay to civil service physicians, the disparity between Commissioned Corps and civil service could become much greater, maybe twice as much. I think that would have a terrible effect on your Commissioned Corps staff.

Also, unless you provided funding for that overtime pay, it could really create a lot of difficulty in managing the service unit budgets. Perhaps toward the end of the year when they are running out of money, they would be forced to cut back on other staff in order to continue to pay overtime to their physicians. One thing I did learn in studying the Indian Health Service is that the staffing and pay questions are very complex and have been worked out over many, many years, and should be approached with caution.

The Indian Health Service is now making an increased effort to recruit physicians on a voluntary basis. They had a task force that pointed out their needs and developed some strategies, and they're implementing that plan this year. They were more successful than last year. I think they recruited 63 voluntary physicians compared with the usual about 50, and they got about 140 physicians from the National Health Service Corps. So it looks like for this year, they managed to make the 200 target they need. However, you can see that the majority of these new physicians are from the National Health Service Corps. And as their numbers decline, there really are serious questions about whether the voluntary recruiting program can successfully recruit up to 200 physicians a year. They've never been able to do it before.

Obviously, there are serious obstacles to recruiting for the Indian Health Service. It's not just the salary. It's also the fact that these are very isolated locations, and some of the facilities are not new, they don't have all the new equipment. IHS facilities don't have all the support staff that physicians coming out of a university teaching hospital might expect to have. There are other obstacles as well.

Congress can continue to support the Indian Health Service in its efforts to recruit voluntary physicians, but there seems to be agreement that there needs to be a means of recruiting obligated physicians, like the National Health Service Corps, to replace National Health Service Corps physicians that are lost. The general consensus that I heard is that a loan repayment program is probably the best approach to take at this time. And that's what is being considered by this bill.

Finally, and I think Dr. Johnson will talk about this more, it's not only a matter of recruiting physicians. The problems of retaining the staff are really very severe. Unfortunately, the problems of retaining staff are much more complicated than recruiting them, because it depends on the quality of the overall system—the quality of the hospitals and all the support staff. This is a problem area that sometimes goes beyond the Indian Health Service into things like community services, and housing, and the participation of tribes in making people feel welcome in their communities. The provisions in S. 1475 try to address some of the problems of retention, and that certainly is useful.

Thank you.

[Prepared statement of Ms. Smith appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. Smith.

Dr. Johnson.

Dr. JOHNSON. Mr. Chairman, I have a prepared statement that I would like to have submitted for the record.

The CHAIRMAN. All of the prepared text will be made part of the record.

## STATEMENT OF DR. EMERY JOHNSON, M.D., FORMER DIRECTOR, INDIAN HEALTH SERVICE, ROCKVILLE, MD

Dr. JOHNSON. Then I would just like to summarize a few points from that testimony and in support of Ms. Smith's comments.

I agree with the findings of the Office of Technology Assessment on the clinical staffing. I think the findings are correct. And I want to emphasize first, that the problem of clinical staffing is, in fact, real, and it's an immediate problem. It is not theory, it's not hypothetical.

The problem is not only with physicians. We always want to talk about physicians. But I want to reemphasize what Ellen said, that the nursing shortage is also going to cripple the program if we don't get a handle on it. And that is an extremely difficult one as well, because it's an overall shortage of nurses. I have a daughter who's a registered nurse out at a hospital in Bethesda. And I hear every night the stories of the nursing shortage and the difficulty that they have of keeping anywhere close to a full staff right here in this metropolitan area. And so you can imagine the problem of retaining a nursing staff at Pine Ridge or Rosebud or places like that.

Another point to make is that this is a real problem because we're dealing with real people. The patients out there are real people and they're in need of medical care and nursing care. It's not a hypothetical issue. It is a real problem. If we don't have medical staff, nursing staff, Indian people are not going to get health care. And they're the ones then that are going to be suffering, and they're the ones that are going to be in pain. And so, we've got to deal realistically, up front, and immediately with that kind of a concern.

Ellen mentioned retention. And I want to emphasize that. The real issue here is retention, not recruitment. The Indian Health Service has recruited enough physicians to last them into the 21st century. But the retention rates of 5 percent clearly indicate that that's where our problem has got to be. Retention is not something that is susceptible to easy and quick solutions. We have some ways to deal with recruitment, but retention is a longer term issue. And again, I think that we ought to look in this bill, of those factors that are related to retention, as beginning to build that foundation of support that we need for the long term solution to the problem, which is, in fact, retention.

Congress has a role to play. The Indian Health Service has a role to play, and I want to emphasize that I think the tribal governments have a major role to play. And again, one of the issues in this bill is to try to impress upon the tribal governments the importance of the role that they can play and should play, and many of them have played, in this whole issue of recruitment and retention.

The bill that we have before us, I think, is the best immediate solution to hold off the crisis that's coming down the road. I know of no other alternative to address the problem, than the things that we have in this bill. But I want to encourage again, the committee, to think about the long term solution. What does it take for retention? Ellen has mentioned some of them. You've got to have decent clinical facilities, adequate medical equipment, and radiology equipment. You've got to have adequate nursing staff, and support staff. You've got to have adequate staff housing. But there are a couple of things that sometimes we forget about.

One is that to get the kind of people that we really want, the kind of physicians, nurses, dentists, other professional staff we really want, they need to be part of and feel themselves part of a program that is really accomplishing something, not just holding back the tide, but part of a dynamic, moving program that is doing real things in concert with the tribal communities to improve the health of those people. That's the way we get the kind of professional staff that really pays off in the Indian Health Service. And how are we going to get that?

We talked about this in the oversight hearing in February, and I want to talk about it again. We've got to come to some understanding about supporting a stable budget for the Indian Health Service. We go through this annual ritual, when the President comes in with a budget request that would decimate the program, if Congress had ever gone along with it. And this has been going on for years.

And what happens, when this occurs? The doctors out in the field, they don't understand, as we do within the Beltway, that a president's budget is just a proposal. It is not a reality. During the 12 years I was Director of the Indian Health Service, I never had to live with a presidential budget request. But the doctors out in the field, in Kayenta or Kotzebue, or wherever they are, they see this. The doctor's already stressed; his nursing staff is already short; and he sees a budget that proposes that he may lose 10 percent of his nursing staff and his support staff. He looks at contract health services; he already can't get all the specialty consultation he needs; he already has a waiting list of patients for elective surgery. And the doctor says, that's going to get cut back 24 percent. He says, I cannot practice that way. So what happens, between the time that the President's budget is presented in January, and the time we finally get one passed in September or October, many of these—the best folks, the ones that have the high professional integrity and so forth—they're saying we cannot practice under these conditions, and they're gone. It is too late for them. We have lost them by the time the Congress wisely rejects the President's budget proposal, and we start all over again.

And what we do here, Mr. Chairman, is we create a vicious cycle. As we lose people, new people who could potentially be recruited, say, whoops, just a minute, do I want to get myself into the situation where the program is going down hill, where we've got less, the quality of care is going to be even less? Can I professionally work in that kind of a situation? So you have people who might come on board in a dynamic positive program, who say, I don't think I really want to get involved. So you lose potential recruits. At the very same time, what's happening, is you're losing the good people who say, I can't continue to practice under these circumstances. So it's a circular thing. As you lose recruits, you don't get the recruits. As you lose recruits, you lose more. It's like a toboggan slide; once you get started down that slippery slope, who knows where you can stop. So I'd like to encourage us not just to look at recruitment/retention in the traditional sense, but to look in terms of how do you provide the kind of stable commitment to the program so that physicians and nurses and other professional staff can expect that they will be able to practice, year after year, an adequate and reasonable level of quality of care.

Now, at the same time, if the National policy of Indian Self-determination, the tribes taking over and managing their own programs, is in fact what we're all about, and I firmly believe it is, this process is the greatest barrier to the success of the self-determination process. Because what tribal leader is going to want to assume the responsibility for a health program in the face of the annual threat to pull the rug out from under it, and so that he's going to have to say to his people, I'm sorry, but our health care is going to be worse next year?

So we've got two things here. We've got the recruitment/retention issue as it relates to Indian Health Service, and just providing basic care. We've also go the problem of supporting the Congress, the law, the President's policy really, of Indian Self-determination. And by not addressing this issue, we are really applying a barrier to both of those.

Well, let me get on to the specifics in the bill. As I have mentioned earlier, Ellen Smith said, and I quite agree, that the loan repayment program that is identified in this bill is the one single thing that I know we can do immediately to stem the tide. Scholarships are fine, and they have served well, but the lead time for scholarships is entirely too long to be of any immediate help. That pipeline was cut several years ago. To fill it up again is going to take too long and there are other reasons that I could give you why I think loan repayment may very well be the best way to go, even over the long term.

However, I've got a couple of comments about it. One is that I think that we ought to add to the loan repayment a provision to allow those volunteer professional staff who are already out there to be permitted to participate in the loan repayment program. They have already made a commitment to come out and work in the Indian communities, and it would seem unfair to provide loan repayment for somebody that is now recruited off the street, but to deny those people who are now volunteers, who are not on obligated services, participation in a loan repayment program. I know of more than one out there who I think could be retained. If they have heavy loans to repay, they can't pay those loans on the salary they're going to get in the Indian Health Service. But if we offered them loan repayment, to stay another two years, or whatever, I think that there are some physicians out there who would stay with us for another period of time, if we allowed them to have loan repayment.

I mentioned that the scholarships are not the basic solution here, but I would like to qualify that by saying I think we need to look differently at the Indian Health Service scholarships that are in Title I of the Indian Health Care Improvement Act. I think they are serving a quite different purpose. They're serving a purpose to try to eliminate the tremendous disparity we have in Indian people in the health professions. We're not going to trickle down any kind of a system that is going to provide support for Indian physicians, nurses, dentists and so forth, really other than the Indian Health Scholarship Program. And I think it's also important that we have Indian people providing services to their own people. And they can't do that unless we have a mechanism for them to be trained. I think the Indian Health Scholarship Program in Title I of the Indian Health Care bill is a very critical one. And I don't want you to think my comment about scholarships in general, in any way suggests that the Indian Health Service scholarships are not needed—quite the contrary. And I would encourage the committee to move ahead on S. 129. I think it's a critically important bill, and the IHS scholarship program is one that I think needs to be continued.

We also have in S. 1475, a number of provisions for pay, for salary. As Ms. Smith said, it is a very murky issue when you're trying to compare salaries between Commissioned Corps and civil service. It's murky when we're comparing those salaries to private sector salaries and so forth. But I think one thing is perfectly clear, that the salaries in the Indian Health Service are substantially below the salaries, regardless of what personnel system you're in, they're substantially below the salaries that you're going to find out in the private sector. And remember, we are in competition, or the Indian Health Service is in competition with the private sector, for these kinds of people.

Now, the pay in the Indian Health Service has never been equivalent to the private sector, and I don't suspect it ever will be. And I'm not sure it ever should be. But there comes a level when that disparity gets to some certain level, and I can't precisely identify it, when it really becomes a serious barrier. And I think we have to provide mechanisms to close that loop to some degree. Now reasonable people can disagree upon the method, and I'm sure you'll have discussion from the Administration of their concerns about various things, but I think what we should not disagree on is that we must do something. To simply say we need flexibility, and we need to think about these things; we don't need to think about these things, we need, first of all, to use the authorities that are already in statute, and apply them in an intelligent way, and if the Administration is not interested in applying the authorities they already have, then maybe Congress has a reason to be a little more explicit as to what they want them to do.

On some of the others, when we're looking at new authority, I think one can argue whether this particular bonus approach, or this other one is better. And I'm not an expert in that particular field, but I do believe that we must do something. Status quo is not going to help us either for recruitment, and it certainly is not going to help us for retention. We must deal with the salary issue if we're going to make any kind of headway on retention.

I'd like to add my personal support to the efforts in this bill to call attention to the importance of tribal governments' role in recruitment and retention. Now, I've said for a long time, the Indian Health Service may be able to recruit, but the principal mechanism for retention is ultimately going to be in that tribal government, and that Indian community. And I think the bill, in many ways, is really giving a clear message to the tribal governments that the Congress believes and encourages them to take that active role through the demonstration projects, through the training in Indian culture. All the participation that we are really looking at in this bill are ways to stimulate the tribal governments to want to get more actively involved. Some tribal governments have done a super job. And I could give you some examples. And when they do really participate in a meaningful way, it does make a difference in recruitment, and it makes a positive difference in retention.

The tort liability is another one that I think is important. It hasn't anything to do with retention/recruitment, but it has something to do with the other major principle that I talked about, and that is the principle of self-determination. The tribes are having great difficulty. And I was at a meeting in California earlier this year when an expert in malpractice made a presentation to the Tribal Health Programs in that State, and painted an extremely gloomy picture of their potential for even being covered under any kind of a malpractice insurance plan. I think that's another one of these barriers that the tribes are going to bump into. It says, gee, we can't afford to get into the business of taking over and operating the program, because we're going to get into this burden of self-determination, and we're going to get stuck with the malpractice issue. So I would encourage you to seriously consider that as an issue.

I'm prepared to respond specifically to any question. I basically support the bill as written, Mr. Chairman.

[Prepared statement of Dr. Johnson appears in the appendix.]

The **Chairman**. I can assure you, Doctor and Ms. Smith, that we have many questions to ask.

There is a vote pending in the Senate at this time, so we will call a short recess.

[Recess.]

The **Chairman**. The hearing will please come to order.

The Chair would like to recognize the author of the measure, Senator Melcher.

Senator **Melcher**. Thank you, Mr. Chairman.

Emery, on the question of there being a lot of doctors, and therefore we shouldn't have much of a problem, I think you address that in your comments and in your prepared testimony. What's the basic thing going to be for retention, isn't it pay?

Dr. **Johnson**. Senator Melcher, I think that there is a minimal level of pay, or I'd say sort of a minimal disparity between the pay in private sector and the pay that you have to provide in the Indian Health Service. I don't see us having to be dollar for dollar comparable, because I think we're looking for the kind of physician who is interested in providing a really unique service. The really best docs that we've got are those that are out there who have a commitment to Indian people and a desire to provide service to that particular population, to be in a dynamic, moving program—seeing the elevation of health status, looking at communities rather than necessarily individual patients. So pay is terribly important, Senator Melcher, but I don't think it is the only thing.

And that's why I'm really saying that if we don't have the environment in which physicians and nurses can practice, and feel that they are making a commitment and a contribution, and things are getting better, the health of that community is improving, the quality of care, the access to care, these things are getting better, year by year, day by day we lose something. I'm sure Dr. Rhoades may not agree with me, but if we were recruiting people solely on the basis that we're going to pay you the most money, I'm not sure we'd always get the kind of doctors we need. My concern right now is that we're not anywhere close to being competitive and we should not ask the doctor to make a major sacrifice in his income in addition to the sacrifice he may be making in living in some of the less desirable parts of this world, and living without amenities and so forth, that many of them have been brought up to expect. So I think it's a balance, Senator Melcher, and I think that's my plea here. We need to look at balance.

Senator **Melcher**. Well, granted that it's balance, but what's the beginning pay now?

Dr. **Johnson**. Oh, I think it's somewhere in the $40,000 range.

Senator **Melcher**. After 2 years it's going to be still somewhere near there, isn't it?

Dr. **Johnson**. Not much more. It's way, way low, Senator Melcher.

Senator **Melcher**. And it isn't after the 2 years that we're talking about?

Dr. **Johnson**. For retention, I think that's true.

Senator **Melcher**. Isn't that the problem, retention?

Dr. **Johnson**. Yes; that's, in my judgment, the principal problem.

Senator **Melcher**. So the pay after 2 years is going to be something less than $50,000 probably?

Dr. **Johnson**. I would think that's correct.

Senator **Melcher**. And that has to be compared to what, $80,000?

Dr. **Johnson**. It's $80,000, $100,000, depending on your specialty, even more if you're in certain specialties.

Senator **Melcher**. So the disparity is just too great?

Dr. **Johnson**. Yes; the disparity is just way, way too great.

Senator **Melcher**. The IHS task force in 1986, says that the scholarship program has in the past provided up to 60 percent of IHS physician manpower. As this supply of obligated physicians plummets, and it's feared that many of the remaining physicians will leave due to severe staffing shortages, and our volunteer, nonobligated physicians expressing interest in the IHS has decreased in spite of the overall increasing supply of physicians.

Now this is 1986, that's just last year. So all right, we have more physicians, but the IHS task force says that it just isn't going to get there. Is that your assessment? Do you agree with that?

Dr. **Johnson**. Absolutely. This grand idea that this surplus of physicians somehow or another is going to flood the land, simply doesn't happen. This is not just the issue, I think, of the Indian communities.

Look at Poplar, MT. For many, many years there were private practicing physicians in Poplar, MT. We closed the Indian hospital in the late 1950's, and built with Federal money, including a lot of Indian Health Service money, the Poplar Community Hospital. And there were private physicians in that town serving the non-Indian population, and there were Indian Health Service physicians serving the Indian population. In the mid-1960's, I recall, the late 1960's perhaps, the last private physician left. And so we had to work out an arrangement so the Indian Health Service physicians were providing medical care to the entire community. That went on for years.

I understand we now have a private physician there who got there because of the National Health Service Corps and the Indian Health Service. But, that's part of the problem, Senator Melcher. We aren't getting private physicians even into the private sector in some of these rural areas. And to expect some of them to get it in these remote Indian reservations, I think, is unrealistic.

Senator MELCHER. Emery, what do you think of making a determination as the IHS report recommends, making a determination by IHS, if the special means might be developed to hire foreign medical graduates. What do you think of that?

Dr. JOHNSON. Well, I have some reservations about foreign medical graduates, Senator Melcher. We have had in the Indian Health Service some very excellent foreign medical graduates, well trained, competent, and culturally sensitive and very good. We have also had some unhappy results.

The problem that we run into is not unique to Indian Health Service. The literature is full of discussions of foreign medical graduates. The State Boards of Medical Examiners have had an enormous amount of difficulty, credentialing these people, trying to make sure that they in fact went to the medical schools, and that they are competent and so forth. And my concern is that if State Boards of Medical Examiners, who are unable to—that's their major business, that's what they're in business for—have trouble doing this, then I'm not sure how we can expect the Indian Health Service, with all of its functions and all of the pressures that it has to handle that function.

The approach that is being used in the bill, however, I think is something else again. Because what you're doing there, is in a sense, setting up a developmental process, if properly handled, so that the Indian Health Service under good controls, and I think that's what the bill is talking about, would bring on foreign medical graduates in a very carefully supervised position, and work with them, and try to understand over the period of this demonstration not only—we talk in the bill, I think, about using them as physicians assistants. I could see the potential of learning from this what is necessary to understand the capability, the credentialing and the competence of these folks, and perhaps then use that as a basis for coming back for additional legislation to deal with, for example, the mechanism of having that year of approved internship, and residency and so forth, in return for obligated service. I can see the potential of this moving into that.

I would not be supportive of some general policy of the Indian Health Service just taking in foreign medical graduates to close the gap. I think we could get into some serious problems with that. But I am supportive of the approach that's being used in the bill if that is done with good judgment and careful control. I would be quite comfortable that the Indian Health Service would do it that way. I think at the end of that period of demonstration, we would in fact know how we could move from that, if we should move from that and what we ought to do.

Senator MELCHER. Thank you, Doctor.

The CHAIRMAN. Thank you.

Do you believe that the number of physicians funded by IHS would be adequate to meet the health needs of the Indian people?

Dr. JOHNSON. Mr. Chairman, I do not believe that the current number of physicians is adequate to meet the current needs, let alone the needs that we see coming up in the future. And I would suggest that it is not just physicians. I think it includes nursing staff and other support staff as well. The Indian Health Service has historically been expected to provide substantially more medical care than I think that they've ever been funded to provide.

The Indian Health Service, unfortunately, for over 30 years has been rationing medical care. We talk about it nationally, as having to get into the concern of how do we ration medical care as a Nation. The Indian Health Service has been in that business since July 1st of 1955. That was the day after I came on board. And we've been fighting that battle for that entire period of years. It is not something that physicians enjoy doing. Thank goodness we've had enough doctors out there who cared about their patients, that are willing to make the kind of accommodations.

But as I mentioned earlier, Senator Inouye, there gets a point where the physician says, I can't continue to practice if the quality is going to drop any more. We have sort of a threshold as physicians, we always want to achieve the very best, but we will make some accommodations, until we get to a certain point and then we have to say we can't do this anymore. And I think that's what concerns me, as we talk about losing our current level of physicians. It bothers me as we see populations increase, not necessarily with commensurate increases in the level of physicians and other staff to serve that population. The kind of stresses, I think, then begin to erode the program and eventually, I think, the program could simply come unstuck.

The CHAIRMAN. I believe in response to Senator Melcher's question, and Dr. Rhoades can verify this, the incoming physicians under IHS gets $45,000 per annum, and the scale for physicians outside would be from a low of about $60,000 to a high of about $100,000.

Dr. JOHNSON. That's probably about right.

The CHAIRMAN. You have indicated that this measure would serve the present needs, or the immediate needs, the immediate crises, and on a long term basis it does not address the problem adequately. What changes would you suggest to make this address the long term problem?

Dr. JOHNSON. Well, the loan repayment, I think, is the immediate, as you suggested, the immediate stop gap measure. There are some things in this bill that I think do address long term retention. I think clearly, those initiatives to deal with more appropriate pay. That is a retention issue, not just a recruitment issue.

The CHAIRMAN. What would be the threshold—you spoke of a minimal amount?

Dr. JOHNSON. I don't really know that I can give you a precise amount. Certainly, you know, when you're 20, 25, 30 percent below the outside, that's not reasonable. Five percent, maybe. We've got to come closer than 20 percent deficiency, or 30 percent deficiency.

The issues in the bill that relate to trying to encourage and support the tribes to be more involved in the retention of their medical staff, I think, that's classically an important thing. We need to pursue that.

The support of those programs, for example, the INMED Program that we identify as a mechanism to really not just—just pay people to go to medical school. It has a process that tries to encourage kids going through the school system to aspire to medical and health careers early on. So you take the hard math and science, so that you've got the requisites to get into college to prepare for medicine. And it has had a tremendous record of getting the kids through medical school. Their record of getting people to graduate from medical school, and to pass the State Boards, has been exemplary. And we need things like that to get more Indian people trained in the profession, to serve as role models, to provide services back in their own communities. That to me, is a retention issue.

I think that we've looked upon the issue, if we train kids who come from small rural communities, more of them are going to go back into the small rural communities. Not the 100 percent that some folks thought at one time, but more of them will tend to go back then if we take kids out of the big cities, very few of them seem to want to drift off into the country. I think if we train Indian people, more of them are going to be amenable to living in Indian communities.

There's a number of things in the bill, Senator Inouye, that I think are very clearly oriented toward retention. But there are certain things the bill has not addressed, and I don't know that this is the appropriate bill to address. These, because we're really talking about these budget issues that we talked about in February. And I bring up, again, until we really come to grips with that, we are going to be turning off the good professional staff who say, nobody knows, nobody cares. I'm out here working my tail off, and all I get is "let's cut the budget some more." "Let's take away a few more nurses." That's, I think, probably the most significant. The rebuilding the physical plants is another issue. We can't have an Administration that comes in every year and says, let's not build any more hospitals or clinics. We can't say, you can go out there, but you've got to bring your own tent to live in. If we're going to have professional staff out in these isolated places there's no private housing market, we've got to have the housing for them to live in. That's what I mean, the long term solution is a broad based thing of pursuing a whole series of things.

But I think unless we pursue it across that broad front, we're going to be back here three years from now, five years from now, next week, with another kind of crisis.

The CHAIRMAN. Ms. Smith, according to your survey, next year the last of the National Health Service physicians will be completing their obligation. Is that correct?

Ms. SMITH. Not exactly next year. The information I had from the National Health Service Corps was that—and the numbers change all the time, because people are deferred—1990 or 1991 would be the last year they would have new physicians ready for placement. Each of those physicians would be obligated to serve anywhere from one to four years. What is important is that this year, in 1987, there were about 1,000 new physicians available for placement; but in the summer of 1988, there will be fewer than 500. So there is going to be a big drop beginning next year.

The CHAIRMAN. According to your survey, are we providing adequate health service to the Indian people?

Ms. SMITH. Well, the larger OTA assessment that was published in April, 1986, reviewed health status of Indians, and the IHS delivery system and utilization, and according to that work, the health status of American Indians and Alaska Natives still is lower than that of the general American population. This means Indians have more health problems.

At the same time, Indian utilization rates for outpatient visits were relatively high, but Indian patients were using inpatient care at a lower rate than average for the general American population. That suggests that considering their poorer health condition, Indians were not getting all of the care they probably needed.

The CHAIRMAN. What is the patient/physician ratio as compared to the general population?

Ms. SMITH. I think the total general population, both rural and urban, averages about 1.65 physicians for 1,000 population (1980). In non-metropolitan areas, it's something like 0.8 physicians per 1,000. And the Indian Health Service averages 0.7. So it's somewhat lower than other non-metropolitan areas, but not too much.

The CHAIRMAN. I thank you very much.

Our next panel consists of Ms. Suzan Shown Harjo, the Executive Director of the National Congress of American Indians; Dr. Emmett Chase, President of the Association of American Indian Physicians; and Mr. Gary Farris, Executive Director, Indians into Medicine, University of North Dakota.

Ms. Harjo.

## STATEMENT OF SUZAN SHOWN HARJO, EXECUTIVE DIRECTOR, NATIONAL CONGRESS OF AMERICAN INDIANS, WASHINGTON, DC

Ms. HARJO. Thank you.

My prepared statement you have, and thank you for including it in the record.

To summarize that statement, we do support the bill, and hope that it is coordinated fully with the other bills which, unfortunately, have not gone through the process yet either. We hope that special care is taken when you coordinate with the NHSC legislation, which is not Indian specific, and which we feel should be, when this bill goes back to the House. We think that could be problematic.

We would like to echo the points made by the distinguished panel earlier about the need to focus not only on physicians, but on nurses and nurse practitioners, because they are least able to access the loan system. Therefore the paybacks are not very helpful to them.

We are in strong support of the requirement in Section 203, that the IHS personnel receive education in the culture and history of the Indian Nation and people with whom they are working. We hope that that means, and would like clarification that that means, also education regarding the traditional medicines, the traditional foods, and the traditional healing ways, if they are still applicable today, to those Indian peoples. We think this is most important to treating the whole person, and that it is vital that the personnel understand the culture and history. It is also vital that they understand the physiology, and the psychology, and the atmosphere, if you will, of the people where they are working. For many Indian Nations and tribes this is not, unfortunately, a consideration. For many, however, it may be consideration, especially when we are dealing with the birthing and with the dying arts.

In title I of the bill, it says that a person is eligible for a loan repayment only if they are in a profession deemed necessary by the Indian Health Service. We request that the bill, or the regulations, require that this determination of necessity be based on actual data, and based upon tribal assessment of needs. We know that IHS does an assessment of needs each year, which it unfortunately does not share with the Congress, and we would hope that they are required to do so in the future under some legislation. That is one assessment of needs. It is not necessarily based on the tribal assessment of needs. And, we don't know, since it's not public, whether or not it is based on actual data. And, we would be interested in seeing that come forward and of having this as a requirement in this legislation.

We wonder if the penalty in section 104 for breaking a contract is severe enough, and wonder if that shouldn't be increased. Because there are still people who break contracts because companies or communities are willing to pay the penalty to get the doctor, and that's even if they're three times greater.

We request that the report for Section 105 also provide information regarding the number of people with scholarships and loan repayments who are obliged to work in Indian facilities, and not just to require the total number of people in loan repayment and scholarship programs, but who actually ends up in the Indian facilities. And so we get an idea of what kinds of people and where they're working we're really dealing with, and how to target this in the future.

We request that section 202 and section 204 provide that tribal colleges are eligible for grants under these sections. Section 202 says they are eligible, but not specifically mentioned. They would be eligible under it. Section 204, under that section, the tribal colleges would not be eligible and we think they should be eligible under 202 and 204.

The testimony closes with information about the tribal colleges, and lists the number of new medical personnel needed when the Rosebud Hospital is constructed. And this is one of 12 IHS hospitals and clinics in the construction or construction planning stage.

And the last paragraph of our testimony offers a specific suggestion regarding language which would include tribal colleges under section 204.

Thank you very much, and I do want to reiterate that we do support the bill, and we'll be happy to continue working with the committee staff and others to see that this gets enacted, and to help where we may in this coordination, which we feel is so important. And, I want to especially thank the sponsors of this legislation. It's a joy to see something positive for a change.

[Prepared statement of Ms. Harjo appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. Harjo.

Dr. Chase.

## STATEMENT OF DR. EMMETT CHASE, PRESIDENT, ASSOCIATION OF AMERICAN INDIAN PHYSICIANS, OKLAHOMA CITY, OK

Dr. CHASE. I just wanted to go through my written stuff here first of all, and then I assume you're going to ask me questions afterward, otherwise I'll just go through everything that I wanted to cover. Is that the way it's going to work?

The CHAIRMAN. If you would like to, you can just proceed. After the panel finishes, we'll be asking questions.

Dr. CHASE. OK.

Well, I'm Emmett Chase, and I'm the president of the Association of Indian Physicians, and several of us went through the bill together and decided on these things as the main concerns of our association.

If you look at my written testimony, on page 3, starting almost at the bottom, the last paragraph there, is where our actual dealing with the bill starts.

Title I, Section 101, Part (b), eligibility to participate in the Loan Repayment Program. Under paragraph (1), specifying that an individual be enrolled as a full-time student and in the final year. This paragraph should require that a student must have been enrolled as a full-time student in an accredited institution in the past. An individual should be able to demonstrate successful completion of a program leading to a professional degree. This would ensure that an individual would be immediately available for service rather than waiting for completion of the program. The same stipulation should be made for paragraph (2) for graduate programs. Paragraph (3) should add that an individual should achieve board eligibility/certification in a medical specialty or be certified in an allied health profession prior to loan repayment. This again would help to ensure the maintenance of higher quality health care delivery to American Indian people.

Title II, other recruitment and retention provisions. A section should be added that addresses the problem of impaired providers as a quality assurance and retention strategy, meaning impaired providers, doctors with drug abuse problems, addiction, things like that. There should be a mechanism for identifying them, and getting them into treatment, and then thereby maintaining good quality assurance.

Section 205, paragraph (a), which calls for advance training or research. Clarifying language should be used in stipulating that the research activities be directed toward elevating the health status of American Indians.

Section 208, Foreign Medical Graduate Demonstration Project. This provision raises some serious concerns with the AAIP. If this provision is to be adopted, the target group of health professionals should be foreign trained Americans. We should not encourage the immigration of foreign nationals that might result in a significant shortfall of health providers in their own country. In addition, it is generally conceded that there are significant cultural barriers between white American society and Indian people which at times impedes effective delivery of quality health care to Indian people. We feel that the importation of foreign nationals into the IHS will only make this problem worse.

Section 109, paragraph (a)(1), preference for service on this advisory panel should be given to American Indian physicians or other Indian health professionals.

A new section should be added to include a comprehensive analysis of attitudes of health professionals that affect retention in the IHS, meaning that surveys should be done of a large number of physicians that have worked in the past for Indian Health Service, to find out the reasons they left Indian Health Service. This analysis should include a special review of the recruitment and retention efforts made in regard to Indian health professionals.

We just wanted to emphasize special recruitment programs for recruiting Indian people to work for Indian people.

So that covers my written testimony, and that was basically our review of the law together. Most of these other things are just my personal views and comments and opinions, and just should be accepted as that.

I think the problem in different communities varies. Some places the level of health care is much better than other areas, obviously. Some places they have maybe $700 per patient per annum, spent on a patient, whereas in others areas, like in isolated areas of Montana, may be $17 per year is spent on each patient. So there's a large discrepancy of care between service areas that has to be corrected.

Improved communication of the available worksites is important. I, being an Indian physician, I have no idea what available worksites are available in Indian Health Service. I have nobody knocking on my door, except private people with health care associations, and stuff, asking me to work for them, and I don't get anything from Indian Health Service saying, please come join us here, we have this need. We have this worksite available. And there is no communication of anticipated available worksites, as well, nationwide. Like if I knew in a year's time that there would be a position available in this location, I could plan in advance to move to such a worksite. But increased communication in general has to be improved.

We just had our National Conference in Spokane, Washington. And at that conference, we didn't have any recruiters from Indian Health Service at all there, this time, that I was aware of. They didn't have a booth set up, or anything to encourage our medical students to come into Indian Health Service, as an example. And I think if there's an interest in getting Indian physicians, they're going to have to start making an effort to recruit at our National Conference, and otherwise Indian physicians.

In my opinion there should be a clearinghouse of information to be sent out on request for each area, if possible, describing the area, describing the amount of physicians already in the area, and that sort of thing, of anyone interested in working in different areas. I don't know, again, across the board community to community, that's going to vary. I know some places already have a good recruitment program going, like the Aberdeen area. And my experience with Indian Health Service thus far, is the Aberdeen area is probably the only area that has an active recruitment program.

I think one thing that will help retain doctors in Indian Health Service is to establish support groups for the existing Indian doctors, or the existing Indian Health Service doctors. They need to meet as a group and discuss their problems and the issues that are deterring them from staying in the Indian Health Service. And I would recommend an effort be made by either the Indian Health Service people providing mental health workers to facilitate these support groups or otherwise to help nurses, doctors, their families to cope with living in an isolated situation in Indian Health Service areas.

I feel that one of the hardest things for doctors in the Indian Health Service to deal with is that most of them are not trained to deal with problems in Indian health communities. They're not trained to deal with the addiction that occurs in Indian health communities. With alcoholism being substantial in a lot of areas, and the problems related to alcoholism coming in on a daily basis to emergency rooms and stuff like that. With the majority of medical schools in the United States not having programs specifically on addiction, with the majority of medical people that go into Indian Health Service not having had specialty training in addiction and drug abuse and alcoholism, and even smoking, they have no way of dealing with these problems. And these problems are chronic problems. They recur over and over again, so they keep seeing these patients back, putting stitches in their head, taking care of broken bones after car accidents, taking care of homicides, taking care of suicides, all related to the drug abuse problem.

The other kind of problems that they have to deal with are nutrition disorders, and you can relate that to heart disease; to hypertension; to diabetes; to some of the arthritis that goes on in the Indian communities. And the obesity problem. All of these nutrition disorders have to be dealt with, and these nutrition disorders bring back the patient again. They're chronic illnesses that these people have to deal with for their lifetime. And yet there's no support systems in existence for these people to deal with these problems.

I currently work for a population of 97,000 Indians in the Los Angeles Urban area. Probably at least 50 percent of them are Federally eligible for Indian Health Service care. We have one nutritionist, she spends 15 percent of her time working with the medical clinic. So essentially, she's completely overwhelmed and overburdened.

These kind of support things, I have to stress over and over with, because they are the things that are making the doctors leave. Because doctors are used to the idea of curing people, making them well, sending them home and it's all dealt with. In fact, the American system of dealing with medical care is exemplified in the DRG requirements, that say when a person is hospitalized, they have this much time to get well. In the same sense, that's the way medical students and medical doctors are trained. They're trained to cure people, deal with the problem and it's over with.

But in Indian health, these people keep coming back, and they keep returning because of their addiction problems, because of their nutrition disorders.

And the third and final problems they have to deal with is the infectious disease problem, which I understand the infectious disease problem is getting better. It's improving, but the tuberculosis rate, for example, is substantial. The morbidity due to infection is substantial. The diagnosis of heart disease from past undiagnosed rheumatic heart disease is substantial, as an example. AIDS is becoming an issue, with 39 cases in Indian communities now. And the cost of that care, and the cost of the personnel and the increased need of personnel to deal with those problems is increased. But the infectious disease problem is more a reflection of the community's social, economic status, rather than anything else.

There definitely has to be more tribal involvement. I think the tribe has to get involved in reviewing applications or even inquiries about employment. I, for example, went and applied for employment at a Indian Health Service facility in Durango, Colorado, and while I asked about it, the person who was there told me, well, do you have time to come down and interview, we'll set up an interview, we'll call you up, tell you the time and date to come down and interview. So I waited for two weeks and he never called back, so I called back, and he said, well, the position's been filled. And the tribe had no idea that I was even interested in working in the area. They had no idea that I even inquired, I would imagine. But things like that happen on a daily basis, and not only to me, but to other Indian physicians. So, I think there has to be more tribal involvement on reviewing inquiries about employment.

Also there has to be a stand by the tribal governments to support health issues. There has to be statements by the tribal chairmen, the councilmen, saying that we will no longer tolerate alcoholism in our communities; that we will no longer tolerate these at-risk behaviors in our communities. The health boards have to make a stand and say, we will no longer allow smoking in our health boards. And they have to make a stand and support the health community. There's been a lack of that for Indian Health Service. I mean, if anything, there's been just the opposite. A lot of people degrade Indian Health Service. A lot of people degrade the Bureau of Indian Affairs, because of past relationship with them, and dealing with housing, dealing with irrigation, dealing with water systems, you name it. And they have these bad impressions about Indian Health Service. But that has to change and the tribal councils have to change that, at least regarding health and health issues. Because it's their communities that are hurting the most.

There has to be more flexible contracting, meaning that the physicians that are hired should be hired however they want to, they should be able to determine the way they want to work, if they're not service obligated. They should, if they want to work 6 months in a place, say I want to work six months here in this isolated area, and be allowed to do that. Right now, Indian Health Service can't allow that under existing legislation.

There should be a program to allow people to take time off in isolated areas, to allow them to go on extended vacations when they are in isolated areas, support for them to go to continuing education. A lot of times I talk to physicians in Indian Health Service, and they say I can never get time off to do continuing education, because I can never get coverage to come in and take my place while I go out and get the continuing education. And that doesn't just happen in rural areas, it happens in urban areas as well. So if we can contract a lot of private physicians to do 2-week stints in different isolated areas, then we can allow the physicians more time off, more availability to go out and do what they want to do.

I think probably the biggest issue with Indian Health Service doctors, and I can say this until I'm blue in the face, and you can say it also, but the main problem with Indian health doctors is they're burnt out. And they're burnt out really badly, because most of the time they're overworked terribly. And they don't have the support that they need to adequately treat the population. You know, the waiting list concept is just incredible. I mean, you know, when you look at things like mammograms for ladies over the age of 50, which is recommended across the board, as standard of health care, and you review the medical records and see how many people are referred for those. And if they're referred, how long they have to be on the waiting list before they get those kinds of standards of care. Acute medicine is the priority in Indian health. I've had doctors in Indian health say to me that, boy when I was going through training for family practice, I was doing primary care, I was seeing to it that everybody got their immunizations, everybody got this, you know, taken care of, everybody got their pap smears, their mammograms, their chest x-rays, their EKG's, and now working for Indian Health Service, I just do a lot of stitching up, a lot of repair broken bones, a lot of seizure disorder stuff, a lot of drug dependency, a lot of alcohol abuse, and problems related to that. And they just can't believe it. They're overwhelmed. They can't deal with it.

There has to be improved opportunities for the employees, and that's what it gets down to basically. I was thinking, maybe there can be some kind of networking between urban and rural programs, where the rural doctors are able to go to urban communities and work for a 6-month period of time and get all the continuing education they want and then go back to the rural community and serve there, and while they're in the urban area, they can serve in the urban clinics.

Again, the housing issue. I think that no matter who you are in America, you always want to realize the American dream, and that's to own a house, own property, have two cars, and if you're a doctor, you want to make sure one of them is a Mercedes. And if that's not realizable in Indian health, then it's not going to be competitive to the general population of doctors. Maybe if the Government subsidized land for the doctors that move to communities so they can be land based people, they would be more inclined to stay, by working out some agreement with the tribal groups in the areas.

There has to be more advancement as far as monetary gain and responsibility gain. I just lost a really good nurse at the clinic I work at, because she said there is no chance for advancement. There's only chance for cutbacks, basically. And there is always a threat that the next paycheck would bounce at the bank when she went to cash it.

Certainly there has to be improved working conditions. The working conditions are terrible. My population, where I work, I serve, like I said, an estimated 97,000 urban Indians, and we have one nutritionist that works 15 percent of the time, one public health nurse that serves that community. And that's an incredible statistic, that is nowhere near reflecting the statistic of .7 versus .8 per 1,000 full-time equivalents. The support staff has to be more orientated toward primary care.

I had the opportunity to go to the Hazeldon Treatment Program in Minnesota for addiction, and basically they have four R.N.'s, four to probably eight R.N.'s running the entire medical care of 400 inpatients. And they do most of the work, including detoxification, and monitoring, and treatment of diabetes, hypertension, all based on standing orders. And this concept of standing orders management of primary care is a good idea and a good concept that can be applied to Indian Health Service Nationwide. For example, in my clinic I have standing orders for my R.N. and my public health nurse to be able to refer a 50-year-old lady for a mammogram without me having to write an order for it. They already have that responsibility given to them. Or if they identify someone with a positive T.B. test that hasn't had a chest x-ray, they have the right to order the chest x-ray without me writing it in the chart, because they do it all on standing orders. If we orientate our primary care workers, our nursing staffs in primary care, so that they are able to do more of the primary care, it would free up our physicians to deal with the medical problems that they're so desperately needed for, and they would experience a less burn-out.

More social services have to be developed for the communities. More things like shelters for battered people, for abused children, more shelters for the homeless people, that sort of thing. And there has to be more tribal support in that endeavor as well.

There has to be more available statistics for each specific community so that the community knows exactly what the problems are in their area. And this has to be ongoing statistics like county mortality, morbidity reports.

And there has to be more contracts worked out with specialists in the communities so that referrals can take a better—can be processed better.

I think Indian Health Service itself, and the Government itself has to make a statement of need in the Indian communities.

The things that the Association of Indian Physicians has done in the past were work with their health careers awareness programs, and that has been very successful at getting the number of Indian professionals into medical school increased. We have had a substantial increase in membership just over the past 3 or 4 years. Our funding for health career awareness programs has been cut, and it doesn't look like we'll be able to continue those programs much longer, in spite of the fact that this is the biggest time where the need really is paramount. We teach our medical students—our pre-medical students interview skills for going to their medical interviews. We teach them what to expect. We tell them of our experiences. We offer them a support group. We act as their role models. Many of them come from communities and families that no one has ever been in the health profession before. Through our annual meetings, our funding for annual meetings has been cut back. We've been able to finance students to attend those meetings, but we probably won't be able to this next coming year.

The CHAIRMAN. I hate to interrupt, but how long is your summary going to take? You have been summarizing for 50 minutes now, and we would like to provide time for other witnesses to testify.

Dr. CHASE. OK.

I'll try to speak faster and it will be about 5 minutes.

We offer the ANAMS group, that's the Association of Native American Medical Students. We offer a newsletter to all the people active in our association. We support legislation such as this bill today. We were offering scholarships. Our scholarship monies have been cut back substantially. We're not going to be able to offer our students any more scholarships probably, after this next year. We offer a sounding board for our medical students, a grievance committee as it were. We offer the ability for our students to work with Indian providers in Indian communities.

The other concern I had, and it was brought up before, was the Public Law 638, and the interests of HRSA getting out of the direct care services. The estimate was 10 years that they would be out of direct care services. If this is the case, I think we need to prepare health administrators, financial officers, certified public accountants to take over the roles of administrating health care programs. I think that needs to be added to the people on the list of who these loan payment availability can made to. I think we certainly need more nutritionists, more alcohol counselors, more mental health workers. I think if we don't emphasize that now, we're not going to have the people in the communities to run their health programs.

Currently it is estimated that Indian Health Service services 60 percent of the Indian population. So an estimated 40 percent of the Indian population is not receiving any medical services. Even now with short staff, many of the waiting rooms are filled beyond capacity, waiting to see the doctors sometimes 3, 4, sometimes 8 hours, maybe even more. So probably almost a quarter to a half million Indian people are not being served, and that's a poor statistic in my view.

The rest is covered in the written testimony. Thank you. Sorry.

[Prepared statement of Dr. Chase appears in the appendix.]

The CHAIRMAN. Thank you.

Mr. Farris.

## STATEMENT OF GARY FARRIS, EXECUTIVE DIRECTOR, INDIANS INTO MEDICINE, UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, ND

Mr. FARRIS. I'd like to address primarily the portion of the bill that speaks to the INMED program. I would like to begin by thanking the co-sponsors of this bill for putting forth such a farsighted and progressive bill in my estimation.

An expanded Indians into Medicine Program is the most logical alternative to the soon to be defunct National Health Service Corps Scholarship Program. What could make more sense than INMED's objective of providing American Indian health professionals to address the chronic health manpower shortage in Indian communities? By its very nature, it overcomes a myriad of problem situations encountered when recruiting health professionals for service to American Indian communities.

Just a few points in speaking to INMED's success. In our somewhat short existence, we have 75 health professional graduates, including 53 doctors and 5 Bachelor of Science nurses. Our program is continually growing and one piece of evidence to that fact is that this year INMED will have 14 new nursing students alone. Our student population involved with the INMED program last year was approximately 90, and it will increase over 10 percent again this year.

Over 80 percent of the INMED graduates have worked with Indian people. The INMED program has enrolled 242 Indian students in college and 616 reservation students have participated in our summer institute programs. One of the reasons for our success is that the University of North Dakota School of Medicine has guaranteed the INMED program five slots in each of its first year medical school classes. We also have a very supportive community-based Board of Directors. It is a working board the only one to my knowledge, in that they increase the communications we have with the Indian community at large. They are a support group and both lobbyists and advocates for us in the political arena, and they serve as valuable recruitment aides for us in getting students involved in our program.

Just some comments on the proposed legislation. Setting up additional INMED centers should also include an increase in Indian Health Service 103 and 104 scholarships for the new students that would be identified at the new INMED centers.

I would also like to recommend that the service obligation of Indian students due to receipt of IHS scholarships, and the loan repayment that is spoken about in this bill, be able to be concurrent.

We'd recommend the deletion of the portion of the bill which speaks to the use of foreign medical graduates.

And our final recommendation is that INMED direct the establishment of the new centers.

And again, thank you to the co-sponsors of Senate Bill 1475.

[Prepared statement of Mr. Farris appears in the appendix.]

The CHAIRMAN. Thank you very much, Mr. Farris.

Senator Melcher.

Senator MELCHER. I have no questions, but I want to thank the witnesses for their testimony and their help.

The CHAIRMAN. I have a few.

How many physicians of Indian ancestry do we have presently working in the United States?

Mr. FARRIS. Depending on the association numbers used, whether it's the Association of American Medical Colleges, Association of American Indian Physicians, or our own numbers, it's somewhere between 350 and 375.

The CHAIRMAN. Between 350 and 375?

Mr. FARRIS. Right.

The CHAIRMAN. Is it your testimony that 80 percent of those physicians are presently serving in reservations?

Mr. FARRIS. No.

My testimony is that 80 percent of the INMED grads are serving Indian communities.

The **Chairman**. What percentage of the 350 are now serving in Indian communities?

Mr. **Farris**. Approximately 15 percent. Given that we are only given five slots per year in the medical school class, we can only graduate five a year. And we have graduated 53 in the 10 years that we've been able to graduate students, so we're actually a little bit above. We get an extra one in every now and then.

The **Chairman**. Doctor, how many Indian physicians do we have in the whole United States, 350?

Dr. **Chase**. Well, we estimated 375.

The **Chairman**. And of that number, how many are presenting serving Indian people?

Dr. **Chase**. Approximately 20.

The **Chairman**. Approximately 200?

Dr. **Chase**. Only 20, of the 375 are working for Indian health and Indian health communities.

The **Chairman**. Just 20 are serving Indian people?

Dr. **Chase**. That's correct.

For example, in California, me and one other Indian doctor work for an estimated population of 200,000 Indians.

The **Chairman**. It has been suggested that scholarships may play an important role because Indians may tend to return to their reservations to serve their people. Does that hold any logic?

Dr. **Chase**. Are you addressing that question to me?

The **Chairman**. You told me out of 350, 20 have gone back to their reservations.

Dr. **Chase**. Absolutely. I think that if you want people to stay in a community, if you train the people from the community, they'll go back to that community. It's just that simple. It doesn't matter if they're non-Indian or Indian, eventually they'll return.

The **Chairman**. Then you are telling me that of the 350 Indian physicians, the great majority did not come from the reservations?

Dr. **Chase**. I don't have that statistic available, but we could probably get it for you. Currently we are doing a survey of our Indian physicians to determine that.

The **Chairman**. How important is the problem of tort liability among Indian Health Service officials in the reservations?

Dr. **Chase**. Well, I'll give you an example. At our clinic three years ago, the malpractice insurance was $20,000; last year it was $40,000; and this year it was $80,000.

The **Chairman**. Who pays the premium for that?

Dr. **Chase**. It comes out of the Indian Health Service funding.

The **Chairman**. How important is housing?

Dr. **Chase**. Well, it's like I say, anybody in America is looking to fulfill the American Dream, and that is to own property or a house somewhere. And I think it plays a substantial role in getting people to be land based and stay in a community.

The **Chairman**. Ms. Harjo, in her testimony, indicated that a very important element is the teaching, or familiarizing physicians with the history and culture of the Indian people. Is that very important for non-Indians?

Dr. **Chase**. In my opinion, absolutely.

Me, myself, in fact, just being educated on the Indians that I work with, because I'm not working directly with the tribal people, I work in an urban setting where I have Indians from Oklahoma, South Dakota, North Dakota, Nevada, Arizona, and New Mexico, and I know very little about their culture. I enjoy learning a lot about their culture and certainly it helps me to relate and understand their situations and circumstances.

The CHAIRMAN. Do you work with the——

Dr. CHASE. It would do me great pleasure if I could speak the Navajo language, as an example.

The CHAIRMAN. Do you work with the medicine men?

Dr. CHASE. We're working on doing that in the program I'm working with now. One of the Board members is going to finance it out of her own pocket to get one started. I worked for 3 years for the Pomo Indian Tribe in Northern California, and we did have two medicine people there. Their clinics were even busier than mine most of the time. They were coming in only once a month though. Quite a few non-Indians actually came in to see them for medical care.

The CHAIRMAN. Would it help to have special summer intern programs in Indian country?

Dr. CHASE. Absolutely. I think when I was going to medical school, I did a summer internship at the San Francisco Urban Clinic, San Francisco and Oakland, and it certainly was inspirational to me to work in the community to get a feel for what kind of problems were coming in. And certainly I could identify and relate with the people and the problems that were coming in, and it was very inspirational to me to motivate me to go on through medical school, and to provide medical care for Indian people.

The CHAIRMAN. I thank you very much.

Our next witness is the Director of the Indian Health Service, Department of Health and Human Services, Dr. Everett Rhoades.

We have received your statement, Doctor, and it will be made part of the record.

## STATEMENT OF EVERETT R. RHOADES, M.D., DIRECTOR, INDIAN HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ROCKVILLE, MD

Dr. RHOADES. Mr. Chairman, thank you.

I might just make a couple of observations in relationship to that, and then make myself available for questions that you may have.

I'm Dr. Everett Rhoades, the Director of Indian Health Service. It is indeed a pleasure to appear here today to participate in a very important consideration, as has been well laid out by the OTA and has been addressed very well by the preceding witnesses.

Let me just say that we recognize that there are a number of recruitment and retention problems in the Indian Health Service. We are carrying out a number of actions to alleviate these problems. Although some of the provisions in S. 1475, such as the loan repayment program, would address Indian Health Service personnel requirements, other provisions of the bill raise a series of problems regarding civilian and uniformed services personnel systems.

We object to a number of the bill's provisions establishing or applying new incentives for general schedule personnel in the Indian

Health Service, that are not generally applicable to the Federal civilian employees. As a result, the Administration cannot support the bill in its present form.

The **Chairman**. Don't you think the problem is sufficiently unique to apply unique solutions?

Dr. **Rhoades**. Yes; that is a true statement, I believe.

The question whether the perceived disturbance of some of the personnel aspects of it are sufficient to overcome those unique attributes, I believe is worthy of further discussion. I'm sure we'd be very happy to work with the committee on that.

In Senator Melcher's statement of July 9, in introducing this bill, he noted the recent special report of the Office of Technology Assessment on the clinical staffing of the Indian Health Service, and indicated that this bill was intended, at least in part, to implement recommendations made by OTA. Dr. Robert Windom, the Assistant Secretary for Health of the Public Health Service, testified on April 30, before the House Committee on Interior and Insular Affairs, relating to the OTA report. In his testimony, he noted that the report clearly represents the current situation in the Indian Health Service, and also pointed out that while the problem is one of recruitment and retention of physicians in the Indian Health Service, as other witnesses have pointed out, it is also linked to a broader problem of availability and distribution of other types of health professionals. Dr. Windom described some of the efforts that are underway in the Indian Health Service to deal with health professionals' recruitment and retention. He pointed out that the IHS has developed a recruitment plan in conjunction with the Health Resources and Services Administration, HRSA, within which Indian Health Service is located, to provide health professionals for underserved areas, including the Indian Health Service.

Just as this bill is multifaceted, our recruitment program is multifaceted with funds for clerkships, increased journal ads, increased conference display, increased site visits, and prospective candidate travel. One of the initiatives that appears to be well underway is the development of a medical school advocacy program. I have met, personally now on two different occasions, with about 70 representatives of medical schools, who seem to be very anxious to serve as recruitment agents for us, without cost, in those various institutions.

Let me just close these introductory remarks by pointing out the authorization of the loan repayment program which would permit the Indian Health Service to recruit individual health professionals, including students in their final year of professional school, in exchange for a period of obligated service. The Indian Health Service would be required to repay a certain amount of the student's educational loans. Other provisions of the bill would also authorize grants for tribal demonstration projects, and so forth. Because of the concerns related to personnel matters, certain precedents related to funding of special pay, continued concern about the impact and need to continue to examine the very important and difficult question of extending coverage of the Federal Tort Claims Act, I reluctantly have to say, the Administration cannot support the bill in its present form.

Perhaps I could respond to any questions that you might have, Mr. Chairman.

[Prepared statement of Dr. Rhoades appears in the appendix.]

The CHAIRMAN. Thank you very much, Doctor.

Senator Melcher.

Senator MELCHER. Doctor, I guess you agree—I read through your testimony—that there is a problem and it could become a crisis, or will become a crisis unless there's sufficient retention of the present employees. You mentioned in your prepared testimony, that you have authority to allow for extra pay, but I don't think you've ever used that authority, have you?

Dr. RHOADES. I believe that a number of years ago that authority was used, for reasons not entirely clear to me, through instructions that had been received in the Indian Health Service. It was felt that it was not appropriate. We're in the process, at this moment, of attempting to put together a plan for the reinstitution of that authority.

I am mildly optimistic that we will be able to do so.

Senator MELCHER. Well, you've been there what, 5 years?

Dr. RHOADES. Yes, sir, 5 years.

Senator MELCHER. And during your tenure it's never been used, has it?

Dr. RHOADES. That's correct.

Senator MELCHER. So we'd have to go back to Emery Johnson to find out whether he ever used it in his tenure?

Dr. RHOADES. Yes.

Senator MELCHER. And the basic reason the Administration doesn't like the bill is because it would cost $5 or $6 million, isn't that right?

Dr. RHOADES. There is no question but that given the severe financial constraints that the country is in at the present time, as reflected in the continuing deficit and so forth, that it is a consideration in all of the programs. It's not the only consideration, however.

Senator MELCHER. No, I understand that.

Would it not, likely though, cost the Federal Government a great deal more because they cannot maintain clinics and cannot maintain hospitals, managed by the IHS, that had to refer the patients to other hospitals?

Dr. RHOADES. The experience that we've had to date would indicate that that is the case.

Senator MELCHER. Well, we might, rather than costing $5 or $6 million, as I believe the CBO is going to tell us, or for that matter, OMB too, that the cost will be if it were enacted into law, we might be saving several million dollars a year simply because the IHS facilities are functioning. That's correct, is it not?

Dr. RHOADES. Again, I believe our experience is such that would confirm the validity of the point you make, yes, sir.

Senator MELCHER. I realize that you, yourself, are responding, Doctor, to this imminent crisis, and I know how difficult it is within an Administration that is strapped for funds and has to be cognizant of all aspects of the deficit, but I believe that we're at the stage now where we must act prudently this Fall in order to avoid the chaotic condition that will come, the very sad condition that will come very quickly upon us, unless we do get a reversal.

Dr. RHOADES. Yes, sir.

I believe Dr. Johnson's testimony is correct. The problem is an immediate problem.

Senator MELCHER. And while I commend you and anybody else in the Administration that is attempting to work through this maze of allowing for supplemental pay or bonus pay, whatever we want to call it, to a broad array of physicians, serving in the Public Health Service and for that matter, serving in the military, as well as the Indian Health Service, but I know of no graver crises that we're facing in health care delivery, than there is to our Indian population. And I detected from the testimony just given to us by the doctor that this statistic of seven-tenths of one physician per thousand of Indian people is undoubtedly a faulty statistic. It's probably lower than that. But at the same time, the doctor testified that a grave problem we're facing is burn-out in physicians working with the IHS. And that is such a real problem and such a real mounting aggravation of the crises we're already facing, that unless we can provide the staffing, provide the—well, the commonty of living conditions, the interaction between the IHS physician, the IHS nurse, and the IHS lab technician and the tribal members, we're facing the most sad medical situation that I've ever envisioned in this country.

Dr. RHOADES. I appreciate Dr. Chase raising that issue as well. I believe that is a fairly astute observation. I don't know that it has actually been raised that way in the past.

In my opinion, that problem is not limited to the physicians. I don't think he intended to imply that it was. I see that throughout the Indian Health Service, even though there is a great deal of enthusiasm. And I think that that is largely a reflection of the incredible dedication that the usual Indian Health Service employee has. But in fact, the Indian Health Service employees are overworked and overtaxed. One of the very difficult and distasteful sad parts of my job is ask them to continue to do more than is reasonable for a person to do. That cannot continue. I don't have the figures, but working in the Indian Health Service is a high risk occupation. That's quite clear to me.

Senator MELCHER. I'm pleased, Doctor, that you mentioned that it isn't limited to the physicians. Of course, it extends to the nurses and the other health care providers that are overworked and overtaxed, and are burning out.

Thank you very much, Doctor.

Dr. RHOADES. Thank you.

The CHAIRMAN. Your most recent study on manpower, when did you conduct that?

Dr. RHOADES. I'm sorry?

The CHAIRMAN. When was the most recent study on manpower needs conducted by the IHS?

Dr. RHOADES. Chairman Inouye, the annual planning for the Indian Health Service every year is, in reality, a reflection of staffing needs. That is, as we begin planning for the subsequent year, as well as the formulation of the budget request for the Indian Health Service, we begin assessing the need, community by community in the Indian Health Service, through a famous thing called the Resource Requirement Methodology [RRM]. It has a bad name in some quarters, but to this day no one has been able to produce a system that, in my opinion, is equal or better. The application of standards that we have taken from the American Hospital Association, American Medical Association, American Nursing Association, and a wide variety of professional organizations, some of which we've had to build ourselves because there's no comparable counterpart in this country, actually goes into the reflection of needs every year. Medicine continues to be a very labor-intensive activity as it is and that medical need is reflected as a staffing need.

I don't recall exactly the figure that has been used, but it is a result of the application of RRM. As a matter of fact, I do believe we make that information available to Congress every year. We certainly make the information available to the tribes each year. In the last few years there has been some improvement in meeting unmet needs, as a matter of fact. At the present time, the figure that we are using in 1987 is that we are meeting about 68 to 70 percent of the needs. I'd like to distinguish that from the group that Dr. Chase spoke about as well. That reflects the amount of sufficiency that lies within the Indian Health Service, within the group of Indians within our eligibility criteria. It says nothing of that 40 percent that he mentioned that lie outside the Indian Health Service.

The CHAIRMAN. So you are telling us that you are meeting 68 to 70 percent of the health needs of the Indian country?

Dr. RHOADES. Yes; I think that's an accurate way to express it.

The CHAIRMAN. How does this compare with the outside world?

Dr. RHOADES. There are many, many difficulties with comparing that situation with the rest of the United States. Perhaps Indians collectively might more appropriately be compared to the rural poor in the rest of the United States, rather than the general population. They might more nearly resemble that population. I am not aware of any good comparisons between Indians and the rest of the population.

Inferences, obviously, can be drawn from the status of health of Indian people compared with the rest of the population, and although I'm very excited about the rapid gains that have been made and are being made, in fact, the death rate of Indian people is still somewhere around 1.4 or 1.5 times greater than that for the rest of the population.

It is fair to say, I believe, that based upon those kinds of indices, the health of Indian people is less than that of the rest of the population. One cannot automatically translate that into access to care, however, which is a more complicated figure. Another index that we have used, been criticized roundly for using it, but again, no one has been able to improve upon it, is if one makes an estimate of the per capita expenditure for Indian health care through the Indian Health Service, each year, one comes up with a figure of about, I believe currently, and perhaps not with adjusted dollars, about $650 per capita per year. As you may know, the average per capita expenditure for health care in the United States is about $1,500 per capita per year, so that gap is at least 100 percent.

Now there are a lot of errors in those kinds of measurements. It is my opinion that if one accounted for all those errors, there would still be a gap reflected at least in that per capita distribution. That is very, substantial. I don't know of any other approaches to the problem, other than those two.

The **CHAIRMAN**. Well, if my recollection is correct, in rural America you have 1.3 physicians per 1,000, and in Indian country it's .7 per 1,000, isn't it?

Dr. **RHOADES**. I do not know offhand the figure for rural America, but I have every reason to believe that that's generally correct, yes, sir.

The **CHAIRMAN**. Furthermore, unless statistics have changed, the incidence of alcoholism is highest in Indian country than amongst any other population in the United States?

Dr. **RHOADES**. I believe that's probably true. But let me hasten to add that, and I believe that remains true, I believe the data relating to alcoholism in the rest of the population are just so inadequate that I'm not at all satisfied that the difference is as great as reflected.

Once again, the difference is big enough.

The **CHAIRMAN**. It is bad isn't it?

Dr. **RHOADES**. Yes, sir; no question about that. And it is greater than the rest of the population.

The **CHAIRMAN**. Infant mortality among Indian people is worse than any other ethnic group in the United States, isn't that true?

Dr. **RHOADES**. No, sir.

In fact, for 2 years now, the infant mortality of Indian children is less than that for the rest of the population, and it looks like that may continue. That is one of the great miracles of the last 30 years. As you know, infant mortality may be the index that is used around the world, and I can't emphasize it enough. In fact, the infant mortality rate of Indian people is better than that for the general population in the United States.

The **CHAIRMAN**. What about tuberculosis?

Dr. **RHOADES**. Tuberculosis incidence rate and mortality rate continues about four or five times greater than that for the rest of the population. I don't want to take issue with Dr. Chase's point that there is some evidence that tuberculosis might be increasing a little bit. There certainly are pockets. Notwithstanding the fact that it continues at a higher rate than the rest of the population, tuberculosis is not a great problem at the present time, except under special circumstances.

The **CHAIRMAN**. Can we just say in the general sense, that the health conditions among Indian people are worse than any other ethnic group in the United States?

Dr. **RHOADES**. Particularly if you use the term health conditions, which I believe makes a more general term. I do not believe that the health conditions of Indians as a whole, measured in those ways, is necessarily the worst of any group in the Nation.

For example, a number of the health indices, we'll make these available so I won't try to recite them offhand, indicate Indians are substantially better off than Blacks, in a number of these measures. It sort of depends upon definition and how one is looking at it.

The CHAIRMAN. That is no consolation, is it?

Dr. RHOADES. No.

That's what I wanted to say. I don't want my remarks to be viewed in any way to suggest that things are fine. Things are not fine. Things are serious. And well, I think I recognize the magnitude and the seriousness of the problem.

The CHAIRMAN. Considering the magnitude and the seriousness, the words that you have used in describing the health situation, why is it that IHS doctors get paid less than DOD or VA doctors?

Dr. RHOADES. I do not believe that basically Indian Health Service physicians get paid less than Department of Defense physicians, but I could be corrected on that.

Let's assume that was true. I do not know the reasons for that, except that I do know, having had a part-time experience with the Veterans' Administration prior to taking this job, that there is a special pay provisions for physicians working in the Veterans' Administration, a series of bonuses, that are substantially greater than that exist right now for the Indian Health Service.

The CHAIRMAN. Physician's salaries within the Veterans' Administration, new physicians working full-time without medical certification, earn $66,830.00 a year. What do your doctors get paid?

Dr. RHOADES. The figure that you all used, entry level is about $45,000.

The CHAIRMAN. New physician with medical certification, in the VA earn $68,830.00 per year.

Dr. RHOADES. Yes; I know very well. I've been recruited to the VA, as a matter of fact.

The CHAIRMAN. As of December 31, 1986, for any physician with special pay and bonuses, the average salary, $80,297.00. Can you tell me why we pay our IHS physicians less than that with their working conditions being worse than the VA hospitals?

Dr. RHOADES. Chairman Inouye?

The CHAIRMAN. With this situation being worse than the VA?

Dr. RHOADES. I'm sorry?

The CHAIRMAN. How can you justify recommending that we pay less to IHS physicians than VA physicians?

Dr. RHOADES. I cannot.

In reply to your question, I cannot explain that.

The CHAIRMAN. And I gather that you are opposed to this measure?

Dr. RHOADES. As I stated, the Administration has favored, continues to favor I believe, a loan repayment provision as a way of correcting the problem that we all recognize.

The CHAIRMAN. Do you seriously think that alone would work?

Dr. RHOADES. I think one would have to say that this problem is sufficiently complex, and sufficiently multifaceted that no single activity is going to fix it. Again, I think that Dr. Johnson alluded to that. I agree with that.

The CHAIRMAN. We Americans have prided ourselves in the spirit of volunteerism. We are always talking about volunteering for such and such. I have been told by military experts that if we depended on volunteers in World War II, we would have lost the war. If it were not for the draft, we would not have had enough men and women to serve to defend the cause.

We have depended on the good will of Americans, volunteers to serve in the Indian Health Service at less pay than the VA, at less pay than the DOD. Do you think they'll continue to volunteer?

Dr. RHOADES. They will continue——

The CHAIRMAN. The National Health Service people are not volunteers, are they?

Dr. RHOADES. That's correct.

There undoubtedly are a number of them who would volunteer. There will be people who will volunteer to work in the Indian Health Service because they believe it is the appropriate thing to do. The numbers, in my opinion, cannot be sufficient to meet the need, as you've already so well laid out.

The CHAIRMAN. So don't you think some drastic step should be taken?

Dr. RHOADES. The question of what is drastic or not drastic, I suppose might be subject to interpretation, but more than usual measures are necessary. For that reason, in 1987, I substantially increased the recruitment efforts made by the Indian Health Service, nearly doubled them, for example.

We are going to find a way to deal with the problem of retention. Retention, I agree entirely, is really the problem. And I suspect that if we could retain people longer, we would save an enormous amount of money that it takes to bring people on and let them leave.

The CHAIRMAN. If the Indian Health Service should come forth with some heroic effort and suggest what is absolutely necessary, you would be surprised, the Congress will come to your aid. And this may sound like a very unintellectual type of question, but don't you think that improving the Indian Health Service would be worth more than one missile?

Dr. RHOADES. I don't want to avoid your question, Chairman Inouye, but I am really not in a position to make that determination.

The CHAIRMAN. Well, I can assure you if you decide to wave the flag for the Indians, we'll be there waving with you.

I thank you very much, sir.

Senator MELCHER. One more question, Mr. Chairman.

Doctor, as a physician yourself, isn't this problem of practicing medicine, where you don't have the support, such a serious problem, that even though physicians with the greatest interest for Indian people that's possible, even though with extreme dedication, they must turn their back and leave the situation when the lack of support is there?

Dr. RHOADES. We in fact, since I've been Director, have completed two surveys of physicians having to do with reasons for leaving. And I'd be glad to make those available if they haven't been made available already.

My recollection may be a little faulty, but I do believe that the one before last, which would have been about 1982 or 1983, I believe that the salary was not the factor most commonly mentioned. The factors that were most commonly mentioned as reasons for leaving the Indian Health Service were the working conditions and the support staff. I believe that answers the question that you raised.

Senator **Melcher**. So even with some of the physicians that are satisfied with the salary, because money is not their motivation, their motivation is simply enjoying the practice of medicine and their relationship with their patients, even with that, there are many of them that had to leave just simply because there weren't enough there?

Dr. **Rhoades**. Weren't enough?

Senator **Melcher**. Enough physicians, enough nurses, enough health professionals in general?

Dr. **Rhoades**. Yes, sir.

I've had health workers relate to me, again as Dr. Johnson has testified, that they could no longer permit themselves to be involved with the level of care that they believe was unsatisfactory.

Senator **Melcher**. Well, I only ask you that, Doctor, because I think it is such a telling point, and at the root of all this, whether we like to say it the root or not, the fact is that without sufficient funds to retain health professionals, we lose all, even those that where the money is not the significant thing, there's not enough left to work with them to provide adequate health care and they professionally and in conscience, just turn their back and leave the situation.

I thank you, Doctor.

The **Chairman**. Thank you very much.

Dr. **Rhoades**. Thank you both.

The **Chairman**. Our final panel consists of Ms. Alberta Boyle, representing the American Nurses Association; and Dr. Loren Petersen, Chairman on the Commission on Indian Affairs, American College of Obstetricians and Gynecologists.

Ms. Boyle, Dr. Petersen, welcome.

Ms. **Boyle**. Thank you.

Dr. **Petersen**. Thank you.

The **Chairman**. Do nurses go first?

Dr. **Petersen**. Yes.

The **Chairman**. Please.

## STATEMENT OF ALBERTA BOYLE, MSN, RN, AMERICAN NURSES ASSOCIATION, WASHINGTON, DC

Ms. **Boyle**. Mr. Chairman, and other members of the committee, I am Alberta Boyle, a current doctoral student at the University of Oklahoma. I teach psychiatric nursing at Oklahoma City University and am a Native American nurse of Chickasaw and Choctaw descent. I am an American Nurses' Association minority fellow, and during my tenure as a 1987 minority legislative intern I worked with Dr. Fay Abdellah, Deputy Surgeon General and Chief Nurse of the Public Health Service.

On behalf of the 188,000 members of the ANA and its 53 constituent state nurses' associations, I would like to thank you for this opportunity to address the issue of clinical nursing of Indian Health Service.

Nurses are a vital resource in providing access to essential health services for all population groups. ANA believes that nurses are especially vital in assuring that underserved American Indians and Alaskan Natives receive necessary health care and utilize and participate in the health care delivery system.

Unfortunately, we are in the midst of a Nationwide nursing shortage, which will compound the recruitment and retention difficulties that IHS is already experiencing. As of August the 1st, 1987, IHS has 2,075 permanent registered nurses with 260 vacancies. In 1986 a special IHS task force projected a need to recruit 650 registered nurses per year to maintain present IHS staffing levels. Half of the IHS job offers are turned down and the quit rate is excessive at 22 percent.

Senators Melcher, Inouye and Burdick have introduced S. 1475, a bill to establish an effective clinical staffing recruitment and retention program for IHS. We commend this response to the manpower shortage and endorse the proposed loan repayment program. However, we have some concerns about the bill, and we offer the following comments for the committee's consideration.

One, while the loan repayment program applies to a broad range of health care professionals, ANA is concerned that the need for nurses could be overshadowed by the need for physicians. To prevent a potential bias toward physician applicants, Section 101(f)(i) should mandate equitable access to loan repayment funds. This especially important since nurses have been excluded from the National Public Health Service Corps Scholarship fund.

Two, Section 103(b)(4) should be expanded to include a subsection (d) which would allow an individual in nursing, who is completing advanced clinical education or training in a specialty area, to defer obligated service as physicians are allowed under Section 103(b)(4)(A).

Three, nurse retention must be addressed. A 1983 IHS recruitment and retention study of registered nurses reported that IHS could improve retention by increasing salaries and benefits and improving training and career development opportunities. These measures are still applicable. To be competitive with the private sector, IHS must increase starting salaries; upgrade or apply special pay to those nurses above GS-9; making pay and benefits equal for all personnel systems; and offer monetary incentives for performance, retention or practice in remote areas.

When surveyed, IHS R.N.'s expressed dissatisfaction with existing continuing education programs. Approximately $100–$200 per R.N. per year is available for training. In light of increased costs of educational resources and programs, we feel that $500 is more reasonable. A tuition reimbursement policy would allow for the establishment of a clinical ladder in nursing practice. This would enable IHS to prepare its own nurse clinicians, nurse practitioners and nurse administrators. Their expertise is necessary to prevent the emergence of a second class system of health care for Native Americans.

Four, to provide nursing care which is sensitive to the specific cultural needs of Native Americans and to achieve the ultimate goal of Indian self-determination, IHS should launch a major recruiting effort targeting the American Indian and Alaskan Native.

S. 1475 does not address the needs of the Native Americans who pursue their education through tribal colleges. These students have found that guaranteed student loans are not applicable to their degrees. We have been told that almost 90 percent of the students who attend college off the reservation, return without having completed their degree. Nursing programs coordinated through tribal colleges may prove to be a successful means of educating and preparing Native American nurses. Therefore, it seems appropriate to consider alternatives to the GSL criteria to accommodate those students planning to attend tribal colleges, or to provide specific funds as loans or stipends for them.

Mr. Chairman, we believe that this hearing represents a solid commitment to improve nursing recruitment and retention within Indian Health Service and to thereby improve the health status of the American Indian and Alaskan Native. ANA looks forward to working with the committee to secure the passage of this legislation.

[Prepared statement of Ms. Boyle appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. Boyle. I'm certain the author of this measure, Senator Melcher, will join me in incorporating your suggested amendments, those two that you mentioned.

Ms. BOYLE. Thank you.

The CHAIRMAN. We will have our markup in September. At that time, the new subsection (d) and Section 103(b)(4), and the amendment to Section 101(f)(i) will be offered.

Ms. BOYLE. Thank you, sir.

The CHAIRMAN. It's one of the prerogatives of being Chairman. Dr. Petersen.

## STATEMENT OF DR. LOREN PETERSEN, CHAIRMAN, COMMISSION ON INDIAN AFFAIRS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, WASHINGTON, DC

Dr. PETERSEN. Thank you, Mr. Chairman.

I'm pleased to be here today testifying on behalf of the American College of Obstetricians and Gynecologists in support of a loan repayment program that will help the Indian Health Service recruit an adequate number of clinical personnel.

In addition to chairing the Indian Affairs Committee of the American College of Obstetricians and Gynecologists, I am a liaison member to the American Academy of Pediatrics, Subcommittee on Indian Health.

I am pleased to say that both the American Academy of Pediatrics and the American Academy of Family Physicians also support the establishment of a loan repayment program and in addition, the Academy of Pediatrics has submitted a statement for the record.

The ACOG is convinced that even the most effective voluntary recruitment program will not enable the IHS to meet its manpower needs in the future. Currently, the IHS relies heavily on the National Health Service Corps. For example, of the 37 obstetricians now employed by the IHS, 30 are current or former National Health Service Corps Scholarship recipients.

Because of the dramatic decline in the number of these physicians available after 1988, the IHS faces a potentially severe manpower shortage. It must be emphasized that the IHS has to overcome tremendous obstacles to recruit physicians willing to serve at

IHS facilities. Many of these facilities are geographically isolated, have inadequate medical capabilities, and are understaffed.

Having spent the last 10 years in the Aberdeen service area, I am most familiar with the service units in that area. Rosebud and Eagle Butte have no obstetrician on staff. More than 300 physicians rotated through Rosebud in a single year. All high-risk pregnant patients must be evacuated prior to delivery. Emergency air evacuations out of Eagle Butte make use of an airstrip that is located in a pasture on a hillside, without two-way communication systems or lights.

The obstetrician at Pine Ridge has a workload which far exceeds that of a physician in private practice, including 350 major surgical procedures and more than 400 deliveries in the past year alone. That encourages burn-out for these physicians.

The College is concerned about the poor health status of Native Americans, and the high incidence of Native American women at increased risk for poor pregnancy outcome. Since 1970, the College has visited nearly every IHS service area and hospital to review the quality of maternal and child health and has made recommendations for improvement. Through this cooperative effort, we have seen dramatic improvement in maternal and child health of Indians served by IHS as compared to urban Indians.

To address the issue of recruitment, we sponsor a volunteer program which arranges for obstetricians in private practice to fill short term vacancies in IHS hospitals and to allow IHS physicians time off for vacation or other necessary leave. As result of these firsthand experiences with the provision of health care through the IHS, we have become convinced that the proposed loan repayment program is an excellent and absolutely necessary means for assuring the continued access to health care by Native Americans.

The advantages of the loan repayment program to the IHS are: One, it will help assure a continuing and adequate supply of medical staff; two, it will allow the IHS to recruit physicians with specific clinical or specialty training most needed; three, it will allow an immediate return on investment by attracting physicians at the completion of their training; and finally, it will assist in the recruitment of nurses and other allied health personnel.

The problems of providing health care in rural and economically depressed areas are many and complex. The solutions are not quick or easy. But this program is undoubtedly worthwhile.

We commend the Chairman, the sponsors of the bill, and the committee for your interest and support for this legislation. I'd like to make a special thanks to the committee and specifically to Senator Inouye for his concern and dedication to the Indian people. I share that concern. I've worked with the University of South Dakota School of Medicine for the past 10 years trying to improve maternal and child health in the South Dakota Indian reservations.

The problems there, are overwhelming the socio-economic conditions, the facilities—we had to close our operating room, part of the hospital is condemned, and we had staphlacacaus growing out of the vents in the hospital and the ducts. Who would want their family members to be delivered in that hospital or to have surgery in that hospital with 300 different physicians rotating through there? At one time we had a narcotics addict for a physician, we had to lock up the narcotics, and we were unable to give those patients in labor the necessary medications. I've had the experience of maternal deaths in transport, children's deaths in transport, and I really believe the Indian people deserve more and at least deserve an opportunity for a good health care system.

Regarding this bill, 40 of the 55 physicians in the Aberdeen area are Public Health Service scholar recipients. By 1988, we will have a health care crises that will be monumental in the State of South Dakota to provide health care for the Indian people. I agree with almost everything that has been said here today, including Dr. Chase's statements. Gentlemen, ladies, that's reality. That's reality.

I leave you with this, and it's a personal comment. I guess I have a dream. And after having worked with the Indian people, I've found them to be intelligent, creative, artistic people. And what's happened to them in the last 150 years, is probably nobody's fault in this room. But what happens to them in the next 50 years is our responsibility. And I hope the Select Committee on Indian Affairs of the Senate will give every possible consideration to this group of people. They need health; they need education; they need housing; they need economic development, and I hope that we can at least provide them physicians.

And I thank you and I'll answer any questions, sir.

[Prepared statement of Dr. Petersen appears in the appendix.]

The CHAIRMAN. You can be assured that this committee will not botch up the next 50 years.

Senator Melcher.

Senator MELCHER. Well, I want to thank you both for your testimony. I don't believe there's anything that's more pressing for Indian people than to have an improvement in the health care situation. I don't believe there's any one group in the United States that needs it worse than the Indian people. I think that says it all to us. And I'm very pleased that Chairman Inouye has had this hearing and set the markup date, because I think we have to have this bill this Fall in order to avoid the crises that you have both alluded to and described.

I noted, Doctor, in your testimony the one obstetrician/gynecologist at Pine Ridge. Is that one person there at Pine Ridge? I used to live on the Pine Ridge reservation. That person must be extremely busy.

Dr. PETERSEN. The answer is yes, Senator, he is very busy.

We have a program of affiliation of the Indian Health Service with the University of South Dakota School of Medicine, Department of Obstetrics. That physician is on the University faculty, and so we are able to rotate residents through there and medical students.

With all the clinics, and the incidence of problems, 20 percent of the patients anemic, and a high incidence of infections and diabetes, and those sorts of things, it's considerable work. We have looked at, and I've discussed with Senator Daschle, the possibility of affiliation of medical schools in a broader perspective with Indian Health Service, much like the affiliations between Veterans' hospitals and medical schools. Because the Veterans' hospitals that are affiliated with medical schools have a better quality of care and better services and that sort of thing. And we've discussed this with Senator Daschle, that this might be a possibility of long term affiliation of medical schools across the United States. The University of Washington, and Arizona, New Mexico, North Dakota, South Dakota, et cetera, to assure quality of care and try to get physicians to rotate through the Indian Health Service hospitals and so forth, and help with some of the recruitment and retention problems, because they can have medical school appointments on the faculty, have the opportunity for career advancement, and you can increase their salaries in that way.

And I think—I could talk for hours, I'm sure—there are a number of innovative possibilities to try and improve the health care of Indians; affiliations with universities and medical schools, like the INMED program in North Dakota could be very helpful; giving Indians an opportunity to get into nursing, and allied health fields. And we've tried some of those things. We do have Indian students in medical school and we're very pleased about that.

Senator **Melcher**. Thank you very much, Doctor.

Thank you very much, Mr. Chairman.

The **Chairman**. Ms. Boyle, I am certain that you are aware that nursing is my specialty.

Ms. **Boyle**. Yes, sir.

The **Chairman**. I have been long concerned about the interest we have shown as a Nation in preventative medicine. I think the latest statistics would indicate that at least 2 years ago, we as a Nation spent $1,440 per citizen on curative medicine, and 50 cents per citizen on preventative medicine. Our Surgeon General, a few years ago, and I think it was 3 years ago, issued an historic report which suggested that there are 10 major causes of death in the United States. And of that, seven can be addressed by preventative medicine; smoking, diet, exercise, et cetera.

This is where the nurses can do their thing. And if I look at the health statistics in Indian country, I can't help but feel that with preventative medicine we can resolve some of their problems. And I think nurses can play a greater role than physicians in this area.

Ms. **Boyle**. I would agree, sir.

Dr. **Petersen**. I agree.

The **Chairman**. So I am going to do whatever I can to encourage nurses to join us in working in Indian country.

Now would the loan repayment program help you people in addressing the nursing shortage problem?

Ms. **Boyle**. As——

The **Chairman**. I ask this because I gather that you have difficulty getting a loan?

Ms. **Boyle**. Yes, sir.

And that's—I don't know of too many nurses who have had to borrow $25,000 to go to nursing school. So therefore, for people just working in Indian Health Service facilities for a loan payback, they may have to spend a minimum of one year there. Which would certainly be a problem with retention. So, I'm not sure that that would help the nurses quite as much as some of our other suggestions.

The CHAIRMAN. Doctor, is there any rationale or justification for an Indian Health Service doctor getting paid $45,000 and VA getting $80,000, and DOD getting $80,000?

Dr. PETERSEN. Absolutely not. That's my opinion.

The CHAIRMAN. They come from the same medical schools, do they not?

Dr. PETERSEN. That's correct, sir.

I see no reason for that at all. And the physicians on the reservation are living in some hardship with the problems there, education and housing and all of those sorts of things. And, you know, it's very easy to recruit physicians to the Veterans' Administration and give them a medical school appointment and have the specialists and all of the advantages of the city, but very difficult in the rural, isolated areas. And if you really want to get good physicians there, who will improve the quality of care and supervise it, I see no reason why they shouldn't be at least paid what other physicians working within the Government are. And probably, in many of these places, and I'm not only speaking for physicians, but for nurses and allied health professionals also, there could be some hardship payments there too—what I'm trying to say, I guess, is that maybe the IHS salaries ought to be higher than they are at the VA.

The CHAIRMAN. Dr. Rhoades, this is not to embarrass you, but you won't object if we make a move in the Appropriations Committee to increase the pay schedule for physicians? Seriously.

Dr. RHOADES. Chairman Inouye, I believe that you will find that in fact the history of the Indian Health Service is such that it yields to the wisdom of Congress when Congress acts. [Laughter.]

The CHAIRMAN. We will try our best to be wise, sir.

Well, Ms. Boyle, Dr. Petersen, I thank you very much. It's been a very helpful afternoon, and as you know, we will be conducting a markup on this measure on September the 15th. The record will be kept open until such date. If you have additional testimony that any of you would like to submit, it will be welcome.

Thank you very much, all. The committee is adjourned.

[Whereupon, at 5:15 p.m., the committee was adjourned.]

# APPENDIX

## ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

### SENATOR MELCHER'S OPENING STATEMENT FOR HEARING ON S. 1475, INDIAN HEALTH SERVICE CLINICAL STAFFING BILL

GOOD AFTERNOON, I WELCOME this hearing [redacted] [redacted] ON S. 1475, A BILL WHICH PROVIDES SOLUTIONS TO THE ABSOLUTELY CRITICAL PROBLEM OF MEDICAL STAFF SHORTAGES IN THE INDIAN HEALTH SERVICE.

I INTRODUCED S. 1475 BECAUSE THE INDIAN HEALTH SERVICE IS AT A CRITICAL JUNCTURE IN ITS ABILITY TO PROVIDE SERVICES TO THE NEARLY ONE MILLION INDIANS IN THIS COUNTRY WHO DEPEND UPON SERVICES FOR HEALTH CARE. AS WE WILL HEAR FROM THE WITNESSES TODAY, IHS IS ALREADY SHORT ABOUT 15-20% OF ITS MEDICAL STAFF BECAUSE HUNDREDS OF DOCTORS AND NURSES HAVE LEFT THE SERVICE TO SEEK BETTER PAY AND WORKING CONDITIONS ELSEWHERE.

IHS HAS NOT BEEN ABLE TO REPLACE THESE PROFESSIONALS AND THE RESULT IS A REDUCTION IN THE QUANTITY AND QUALITY OF HEALTH CARE FOR THOSE INDIAN PEOPLE WHO ARE SICK, SUFFERING FROM DISEASE, OR ARE INJURED. IF SOMETHING IS NOT DONE, THE SITUATION WILL CONTINUE TO DETERIORATE UNTIL IT BECOMES A DISASTER.

INDIAN HEALTH CARE IS A TRUST RESPONSIBILITY OF THE FEDERAL GOVERNMENT. I BELIEVE THAT CONGRESS MUST ACT QUICKLY AND DECISIVELY TO AVERT THIS LOOMING CRISIS WITHIN THE IHS. IF WE DO NOT, THE STAGE WILL BE SET FOR DISMANTLING OF THE SERVICE AND CONGRESS WILL HAVE FORFEITED ITS FEDERAL TRUST RESPONSIBILITY TO PROVIDE ADEQUATE HEALTH CARE TO THE INDIAN PEOPLE.

THIS CRISIS HAS BEEN ACKNOWLEDGED IN CONGRESS AND THERE ARE SEVERAL PROPOSALS TO PROVIDE ASSISTANCE. S. 1475, HOWEVER, IS THE ONLY PIECE OF LEGISLATION WHICH IS AIMED SPECIFICALLY AT THE INDIAN HEALTH SERVICE. IT IS THE ONLY PROPOSAL WHICH ADDRESSES BOTH RECRUITMENT AND RETENTION. THIS IS IMPERATIVE BECAUSE IHS MUST REPLACE ABOUT ONE-THIRD OF ITS STAFF EACH YEAR. NEXT YEAR, FOR EXAMPLE, 200 DOCTORS AND 650 NURSES ARE NEEDED. IHS HAS TO DEVELOP METHODS TO RETAIN STAFF FOR LONGER PERIODS OF TIME OR RECRUITMENT WILL CONTINUE TO BE A NEVER-ENDING AND EXPENSIVE PROBLEM. AT PRESENT THE PROFESSIONAL STAFF RETENTION RATE IS ONLY 5%. THIS RETENTION RATE CAN BE INCREASED THROUGH THE PROVISIONS OF S. 1475.

I WOULD LIKE TO SEE THE COMMITTEE PROMPTLY CONSIDER THIS BILL AND REFER IT TO THE SENATE FOR PASSAGE AS SOON AS WE RECONVENE FROM THE AUGUST RECESS, IN TIME TO START THE PROGRAM IN 1988, WHICH IS URGENTLY NEEDED TO AVERT A DISASTER. THIS IS OUR RESPONSIBILITY AND DUTY TO THE INDIAN PEOPLE OF THIS COUNTRY.

TESTIMONY OF ELLEN M. SMITH
OFFICE OF TECHNOLOGY ASSESSMENT
U.S. CONGRESS
BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

## CLINICAL STAFFING IN THE INDIAN HEALTH SERVICE

August 6, 1987

Thank you Mr. Chairman. I am Ellen Smith, analyst in the Health Program of the congressional Office of Technology Assessment (OTA). I worked on OTA's study of Indian Health Care, published in April 1986, and I am here today to report on a follow-up to that study, Clinical Staffing in the Indian Health Service, published in February 1987.

The clinical staffing study looked at evidence of manpower shortages in the Indian Health Service (IHS), and at IHS's sources of manpower and recruiting activities, in view of the termination of the National Health Service Corps (NHSC) scholarship program, which has been the primary source of physicians for IHS in the 1980s. If IHS is unable to replace obligated National Health Service Corps physicians with voluntary recruits, its present health care system may face substantial reductions in services and facilities in the early 1990s.

### Manpower Shortages in the Indian Health Service

IHS provides comprehensive health services to nearly 1 million Native Americans in 32 States, including Alaska, through a system of 51 hospitals and about 130 full-service ambulatory centers. Six of the hospitals and about 50 health centers are operated by the tribes under self-determination contracts. Services that are not available from IHS or tribal programs may be purchased from private providers under the IHS contract care program. In practice, however, contract care budgets are limited and needed services often must be deferred or denied. In some IHS areas, few private physicians, clinics, or hospitals are accessible to provide contract services to Indians.

IHS is the largest health care system in the U.S. Department of Health and Human Services. In 1985, IHS employed about 10,400 individuals, including some 750 physicians, 2,800 nurses, 300 pharmacists, and 275 dentists. Yet this workforce is thought to be 10 to 20 percent short of what IHS believes it needs to deliver its present level of services. Again, budget constraints are a factor: many of the approximately 1,100 staff positions that are vacant at any given time are unfilled due to lack of funding.

IHS also has severe physician retention problems. Only about 5 percent of National Health Service Corps physicians in IHS work even 1 year beyond their service payback periods, and only about 5 percent of voluntary physicians accept a second 2-year assignment. Therefore, IHS must replace one-quarter to one-third of its total physician force each year -- that is, about 200 physicians.

Although the OTA study focused on physicians, some IHS areas -- Navajo and Aberdeen, for example -- report that it is becoming increasingly difficult to recruit adequate nursing staff. Because qualified nurses are in short supply throughout the United States, this problem is expected to get worse.

## The National Health Service Corps and IHS

IHS works hard to recruit physicians and nurses on a voluntary basis, but it is dependent on the National Health Service Corps for most of its new physician recruits. Therefore, the loss of National Health Service Corps physicians is the most serious immediate threat to IHS clinical staffing.

From 1984 through 1986, IHS obtained the services of 130 to 150 National Health Service Corps physicians annually, each for 1 to 4 years of obligated service. During that period, IHS recruited only about 50 voluntary physicians a year. IHS estimates that 60 percent of its new recruits, and 45 percent of its total physician workforce, are obligated physicians from the National Health Service Corps. After 1988, however, the numbers of available National Health Service Corps physicians will drop off sharply, and there will be virtually none after 1991. This decline in available National Health Service Corps physicians is illustrated in table 1 (attached), and IHS will have to compete with Federal prisons, community health centers, and migrant health centers for these remaining physicians.

The National Health Service Corps is being phased out because the Reagan Administration has restricted new scholarship awards. More than 6,000 students received National Health Service Corps scholarships in 1980, but in 1986 there were fewer than 50 (see table 2, attached). The Administration justifies this policy on grounds that a national surplus of physicians will cause new physicians to settle in rural areas, thus providing services to the underserved and eliminating the need for the National Health Service Corps.

Even if more physicians are beginning to locate in rural areas, as some research indicates, this will not solve IHS's staffing problems. Physicians who establish private practices in rural areas cannot serve IHS beneficiaries unless service is authorized by the IHS contract care program, which is limited by its budget. To hire physicians for its own hospitals and clinics, IHS will have to compete with other community organizations, and it often will be competing at a disadvantage. IHS now can pay no more than $45,000 per year for a new 3-year resident family practice physician; some rural communities can pay $60,000 and more. In addition, IHS facilities are among the most isolated in the United States, with associated problems of inadequate housing and community services.

As a further caution against relying on the physician surplus to correct existing maldistribution problems, it should be noted that no surplus is forecast in primary care physicians, the type most needed by IHS and rural communities.

## The Role of the Public Health Service Commissioned Corps in IHS

The Public Health Service Commissioned Corps is an important factor in IHS clinical staffing. Corps officers represent about 20 percent of the total IHS workforce, and a larger share of its clinical staff -- about 80 percent of IHS physicians are Corps members, for example. Although the Commissioned Corps is not itself a recruiting system, IHS recruiters believe it is a positive factor in recruiting and retaining health care staff.

It is difficult to compare the costs of the civil service and Commissioned Corps personnel systems. In IHS hospitals and clinics, however, it appears that Corps physicians are less costly than civil service physicians, primarily because civil servants must be paid for overtime worked beyond 40 hours per week, while Corps officers are not paid overtime.

Doctors in IHS hospitals and clinics commonly work 50- and 60-hour weeks. With overtime, civil service physicians may earn up to the civil service maximum pay cap of $69,000 a year. The Navajo area recently found that while its Corps physicians averaged $41,000 to $45,000 a year, nearly all of its civil service physicians had "maxed out" with overtime pay at $69,000.

The Surgeon General recently announced plans to revitalize the Commissioned Corps, which IHS will want to monitor for possible effects on IHS staffing.

## What Can IHS Do About its Staffing Problems?

IHS needs to make the best possible use of its current staff, while at the same time increasing its efforts to recruit more voluntary physicians and nurses. A special IHS task force in 1986 projected a need to recruit about 200 physicians and 650 nurses a year to maintain present IHS staffing levels. The task force also developed plans to meet those needs, and with increased funding in 1987 IHS has implemented several new recruiting strategies, including a medical school faculty advocacy program and an out-of-service residency program. IHS has recruited 63 voluntary physicians to start work this summer and at least 140 physicians have been assigned from the National Health Service Corps. Thus, IHS's voluntary recruiting program is making progress, but it still is far from its goal of recruiting 200 physicians a year.

There are serious obstacles to IHS voluntary recruiting. In addition to the extreme isolation of IHS facilities, IHS cannot increase its salaries and benefits or offer special recruiting bonuses to compete with the private sector. In fact, IHS cannot even pay the travel expenses of spouses who accompany physician recruits on site selection visits. This may seem a minor point, but it creates real difficulties. Limited funding for salaries, benefits, and malpractice insurance also affects the ability of tribal self-determination contractors to staff their programs.

## What Can Congress Do?

Congress can support IHS in its voluntary physician and nurse recruiting activities. In addition to voluntary efforts, however, there is general agreement that IHS needs a source of service-obligated health professionals like the National Health Service Corps to meet its future needs. Options that are available to Congress include the following.

- Congress could reauthorize the National Health Service Corps scholarship program. But this would be expensive, it is opposed by the Administration and some in Congress, and it would provide no immediate relief to IHS because medical students supported now would not be trained until 1994 or 1995, long after staffing would have become critical to IHS.

- Congress could reauthorize the Indian health manpower training programs under Title I of the Indian Health Care Improvement Act. These programs, while useful, have always been small; and like the National Health Service Corps scholarship program, their expansion now would not produce trained physicians for 4 to 8 years.

- Congress could authorize and fund a new health professions loan repayment program to be operated either by the National Health Service Corps for IHS, or by IHS itself. A loan repayment strategy makes sense. Unlike the National Health Service Corps scholarship program, loan repayment could provide health professionals in any needed discipline to fill IHS vacancies in 1988 and thereafter. The Federal Government would contract with fourth-year medical students, physicians in residency training, and other physicians who agree to work a minimum 2-year assignment in a designated IHS location or health manpower shortage area. In return, the Government would assume up to $20,000 or $25,000 of the individual's educational debts for each year of obligated service (in addition to salary).

## Conclusion

The role of Indian tribes and tribal organizations in recruiting and retaining health care staff should not be overlooked. Active tribal participation in the recruiting process can improve results. Tribes also have a critical role in improving the retention of clinical staff. Retention is a more difficult problem than recruiting, however, because it requires improvements throughout the IHS system: better facilities and equipment, adequate support staff and housing, and better community relations. It is beyond IHS's mission and means to fill all these needs alone. For this reason, the Bureau of Indian Affairs, other Federal agencies, and tribal governments throughout the country must become involved.

Table 1

Numbers of National Health Service Corps Recipients, by Years of Training and Years of Obligated Service Due, All Disciplines, as of March 31, 1986

| Obligated Service Years Due | Total | Year Due On Active Duty | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | Unknown |
| Total | 8,604 | 124 | 324 | 392 | 494 | 477 | 465 | 680 | 1,174 | 1,408 | 1,310 | 996 | 442 | 179 | 89 | 44 | 2 | 4 |
| 1 | | | | | | | | | | | | | | | | | | |
| 2 | 3,176 | 102 | 239 | 325 | 389 | 283 | 253 | 108 | 625 | 638 | 288 | 172 | 97 | 60 | 13 | 4 | | |
| 3 | 3,183 | 22 | 85 | 59 | 104 | 178 | 113 | 423 | 306 | 319 | 480 | 347 | 149 | 88 | 72 | 39 | 1 | |
| 4 | 2,238 | | | 8 | 1 | 16 | 99 | 149 | 243 | 451 | 541 | 476 | 195 | 31 | 4 | 1 | 1 | |
| 5 | | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | | |
| More than 6 | 3 | | | | | | | | | | | | | | | | | 3 |
| Unknown | 4 | | | | | | | | | | 1 | 1 | 1 | | | | | 1 |

SOURCE: U.S. DHHS, PHS, HRSA, National Health Service Corps, 1986.

## Table 2

### National Health Service Corps (NHSC) Field Placement and Scholarship Programs, Appropriations and Participants, Fiscal Years 1971-1986

| Fiscal Year | NHSC Field Program<br>Appropriation ($000) | Year-End Field Strength | NHSC Scholarship Program<br>Appropriation ($000) | Awards<br>New | Continuation | Total |
|---|---|---|---|---|---|---|
| 1971 | $ 3,000 | 20 | - | - | - | - |
| 1972 | 12,374 | 181 | - | - | - | - |
| 1973 | 11,000 | 330 | - | - | - | - |
| 1974 | 9,787 | 465 | $ 3,000 | 372 | 0 | 372 |
| 1975 | 14,035 | 488 | 22,300 | 1,499 | 365 | 1,864 |
| 1976 | 23,662 | 600 | 22,500 | 874 | 1,678 | 2,552 |
| 1976 Transition Quarter | --- | --- | 22,500 | 885 | 1,764 | 2,649 |
| 1977 | 34,334 | 690 | 40,000 | 2,092 | 1,481 | 3,573 |
| 1978 | 39,696 | 1,425[1] | 60,000 | 3,150 | 1,907 | 5,057 |
| 1979 | 62,949 | 1,826 | 75,000 | 2,380 | 4,029 | 6,409 |
| 1980 | 74,075 | 2,080 | 79,300 | 1,772 | 4,387 | 6,159 |
| 1981 | 84,739 | 2,338 | 63,400 | 162 | 4,175 | 4,337 |
| 1982 | 95,070 | 2,782 | 42,300 | 160[2] | 2,289 | 2,449 |
| 1983 | 93,391 | 2,865 | 15,438 | 144[2] | 793 | 937 |
| 1984 | 91,000 | 2,609 | 6,300 | 69[2] | 98 | 167 |
| 1985 | 75,000 | 2,958 | 2,300 | 37[2] | 12 | 49 |
| 1986[3] (est.) | $ 58,300 | 3,304 | $ 2,201 | 35[2](est.) | 7 (est.) | 42 (est.) |

[1] From 1971 through 1978, all NHSC field placements were federally funded. Since 1979, there has been a transition away from Federal field positions to private practice assignment (PPA) and private practice option (PPO) positions. In 1986, only 17 percent of the NHSC field positions (including IHS) were federally funded; 62 percent were PPA; and 21 percent were PPO.

[2] Multi-year awards.

[3] Fiscal year 1986 as of August 1986.

SOURCE: U.S. DHHS, PHS, HRSA, NHSC, "NHSC Notes", Vol. IX. No. 2 Special Issue, September 1986.

# STATEMENT ON S.1475

BY

EMERY A. JOHNSON, MD, MPH

Assistant Surgeon General, Retired
United States Public Health Service

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

AUGUST 6, 1987

I am pleased to appear before this committee to present my views on S.1475, a bill to establish an effective clinical staffing, recruitment and retention program for the Indian Health Service (IHS) and for other purposes. During my 26 years of active duty in the Indian Health Service, recruitment and retention of clinical staff was a never-ending concern, not only of IHS but of the Indian communities that depended upon IHS for their health services. In the years since I retired as Director of the Indian Health Service in 1981, I have continued to be actively involved with Indian health as a consultant to national and regional Indian organizations, Indian tribal governments and other organizations with interests in Indian health. In addition, I have maintained my participation in professional medical, public health and medical administration organizations. My views, therefore, are based on my past and present experience with the Indian health program and with tribal leaders, health staff (both IHS and tribal) and other experts in the field of health services delivery.

As I have testified on other occasions, this committee through its oversight function has a vital role in assuring, through fair and equitable treatment of American Indian and Alaska Native people by the United States and in monitoring the activities of the Federal agencies in carrying out their responsibilities under Federal treaties and statutes, that our government honors its treaty commitments to the Indian tribal governments. In my view, the Committee's study of such critical issues as clinical staffing in IHS and its proposal of remedial legislation is of paramount importance in providing the Federal agencies with the legitive authority required to effectiveky carry out their functions. In addition to these obvious benefits, there is, in my experience, another very important result of this Committee's actions -- the provision of a very clear message to the Indian tribal governments and to the health staffs (both tribal and IHS) that serve them that the health of Indian people is important and that the Government of the United States remains committed to the goal of elevating the health status of American Indians and Alaska Natives to the highest possible level. This message has a very positive impact on the very issue you are considering today -- clinical staffing -- because of its impact on improving the morale of the clinical staff itself.

We all know that remarkable progress has been made by the IHS and the tribal health programs in improving the health status of American Indians and Alaska Natives during the past three decades. Reductions in infant and maternal mortality and morbidity and mortality from infectious diseases represent one of the real success stories in public health. Unfortunately, there still remain serious health problems that inflict an excessive burden on Indian people: the diseases related to poverty, isolation, diabetes and alcohol and substance abuse are examples of the challenges that remain to be overcome if the health of Indian people is to be brought up to that of the rest of the United States populaton.

While I have often expressed my view that solving these remaining health problems will depend heavily upon enlightened and effective community action and changes in human behavior, it is an inescapable fact that the ready availability of well-trained, competent and conscientious clinical staff (physicians, nurses, dentists, pharmacists and others) will be absolutely essential if the health of Indian people is to be maintained, let alone elevated. In fact, one of the principal reasons for the decision of the Congress to transfer the Indian health program from the Bureau of Indian Affairs (BIA) to the Public Health Service (PHS) in 1955 (Act of August 5, 1954) was the expectation, since largely confirmed, that PHS would be more successful in providing the necessary clinical staff. In spite of this improvement, as I testifed earlier, the ability to recruit and retain this essential clinical staff has been a recurring problem from the earliest days of the Indian Health Service.

After several years of relative staff sufficiency, recent events have again raised new concerns about the ability of IHS to provide the necessary clinical staff. In February of this year, the Office of Technology Assessment (OTA) presented to the Congress a special report on "Clinical Staffing in the Indian Health Service". OTA predicted a critical shortage of clinical staff (especially physicians and nurses) within the next two or three years. Since

Ellen Smith, the principal author of the OTA report, has just testified on the details of their report, I will only state that I basically concur with their findings and recommendations.

S.1475 offers, in my judgement, a balanced and thorough approach in dealing with the immediate critical issues in recruitment and retention of clinical staffing for the Indian health program. I will offer specific comment in support of the provisions of the bill but, before I do, I need to share my view that the long-term solution to this problem depends more on retention than recruitment. The reported retention rate of physicians in IHS of only 5 per cent offers graphic evidence of the seriousness of the retention issue. Granted, recruitment must occur before retention but it seems obvious that the best potential for maintaining a stable, competent and caring clinical staff requires that those who are recruited find providing medical service to Indian communities to be a satisfying and challenging experience.

What are some of the most important factors within the influence of the IHS and the Congress that support retention? These would include good clinical facilities (hospitals and clinics), modern medical equipment, adequate staffing (nursing, laboratory and radiology services, pharmacy and others), adequate staff housing, appointment in the Commissioned Corps of the PHS, ability to serve a scholarship or loan repayment obligation and participation in a dynamic and creative community health program that demonstrates progress in community development and improved health status.

Unfortunately, the annual ritual in which the President proposes drastic reductions in the IHS budget serves to discourage retention; physicians who already are over-worked, are without adequate support staff and frequently cannot obtain speciality consultation and elective surgical procedures for their patients see this threat of further deterioration of their clinical practice resources and decide they have had enough. It has been my experience that many of the best clinical staff will persevere as long as there is the prospect of improvement but, when that expectation is lost, they become discouraged and no longer are willing to serve. When, as has been the rule, the Congress wisely rejects the President's proposals, 8-10 months have passed and many of the clinical staff have already made their decisions - physicians and nurses have concluded that they can no longer practice an acceptable quality of patient care with the proposed reductions and have left the Service; the restoration of the clinical funding has come too late. As I have testified before this Committee on another occasion, there must be a basic commitment to stable and adequate funding of the Indian health program if there is to be any hope of a permanent resolution of the problem of clinical staffing. I also believe that success of the Indian self-determination process is also dependent upon the same stable and adequate funding; Indian tribal governments cannot be expected to aspire to manage their own health programs if they are threatened each year with substantial reductions in their ability to provide quality health services to their communities.

It is my view that, as introduced, S.1475 appropriately and effectively addresses some of these retention issues but it would be a mistake to believe that this legislation by itself will provide the long-term solution to the pervasive problem of clinical staffing in the Indian health program. This bill does, however, provide the absolutely essential direction for the immediate crisis; continuing attention to the other clinical staff retention requirements noted above will be required in the future.

Title I, Loan Repayment Program:

The Indian Health Loan Repayment program offers an immediate and, I believe, an effective method for attracting the required numbers and appropriate clinical skills for the IHS. IHS can determine its clinical staffing needs and, through offering loan repayment to those individuals who currently have or will shortly have, those skills, obtain staff in a timely manner. Without this new program, it will be most difficult for INS to make up for the imminent loss of National Health Service Corps (NHSC) scholarship recipients. In recent years, IHS has obtained about 60% of its new physician recruits from the NHSC program. With the IHS need for approximately 200 new recruits each year and an experience of only about 50-60 volunteer physicians each year, it can readily be seen that the loss of the NHSC resource could result in a dramatic reduction in physician staffing. Even if the number of voluntary recruits could be somewhat increased, the inevitable shortage of physicians would result in a further accentuation of the shortage as some of the remaining physicians, already stressed by the heavy workload and shortage of supporting resources, can no longer accept the deteriorating quality of pateient care and leave the Service; past experience has demonstrated this unfortunate result.

It should also be noted that the figures cited above only reflect replacng the current medical staff. The best projections that I have seen of the actual number of physicians needed to provide the essential medical care required by the present population of Indian communities served by the Indian health program is that there is already a fifteen per cent shortage; further shortfalls in filling vacancies will only accentuate the existing problem.

It should also be noted that there is a significant problem in recruiting and retaining other clinical staff, especially nursing staff. The vacancy rates, budget-driven shortages of clinical positions and other disincentives to recruitment and retention that apply to physicians also apply to the nursing staff. In addition, there is a general shortage of professional nurses in this country. We see evidence of this in the Washington metropolitan area today in the aggresive recruiting efforts and high nursing staff vacancy rates in our local hospitals.

Health professional scholarships, while they have been extremely helpful in recent years, simply require too long a lead time to be of immediate help and, in the past, have sometimes resulted in persons being trained for positions no longer needed when their training was completed. However, I do believe that the special Indian Health Scholarships authorized in Title I of the Indian Health Care Improvement Act (PL94-437) are of critical importance for other reasons; the need to increase the number of Indian people trained in the health professions is necessary not only to redress the deficiency in Indian people in these professions but also to enhance the effectiveness of Indian health programs by having service provided by Indian people and by supporting the policy of Indian self-determination. I would repectfully urge this Committee to continue to move the "Indian Health Care Amendments of 1987" (S.129) to passage so that, among other programs, the Indian Health Scholarship program can continue.

Further, under Title I of S. 1475, I would recommend that authorization be added to permit loan repayment to individuals who may now be voluntarily serving in the IHS in return for a specified commitment for further service. There are some clinical staff who do not have obligated service but who have significant loan obligations from their health professional training. It would not seem fair to offer loan repayment as an inducement for new recruits while those who have already shown their interest by serving in Indian communities would not be eligible. Loan repayment contracts for those currently on duty would also be an incentive for retention of these individuals. The provisions for these individuals would be consistent with the provisions already in the bill.

Title II - Other Recruitment and Retention Provisions.

Travel Expenses for Recruitment: Experience has shown that one of the most important factors for recruitment and retention is the acceptance of the assignment by the spouse -- unhappiness in the home leads to loss of the recruit and poor retention. Allowing the spouse to visit the potential assignment location provides for better understanding of the opportunities for meaningful service and gives the Indian community the opportunity to "sell" their program needs to the spouse.

Tribal Demonstration Recruitment and Retention Program: It is my opinion that the most effective method of recruitment and retention is for the Indian community itself and the clinical staff member to form a mutually satisfying relationship. Enhanced retention also makes recruitment more effective; a strong endorsement by present staff that this is a good place to live and work encourages others to join them. A number of tribal governments in the past have had successful programs. For example, the Hopi Tribal Council for many years has had an active and highly successful physician recruitment and retention initiative. Although their community is isolated and lacks many amenities, they were able to maintain a full medical staff who would stay for several years and usually had several physicians applying whenever a position was available. Similar actions by the Red Lake Tribal Council has recently been successful in improving their retention of medical staff. Implementation of this provision should encourage others and will add to the "state of the art" for the benefit of all of the tribes.

Tribal Culture and History: This is another provision that significantly enhances both recruitment and retention. By involving the tribal community colleges and tribal governments, the relationship with the Indian community and the mutual understanding with the clinical staff will be enhanced. Better understanding will provide for better care, more professional satisfaction and improved retention. Along with the Tribal Demonstration Recruitment and Retention Program, this provision signals clear Congressional recognition that the Indian tribal governments have a crucial role to play in the recruitment and retention of their clinical staffs and should further encourage them to become full participants in the recruitment and retention effort.

INMED Program: I have noted earlier the importance of having more Indian people trained in the health professions. The INMED program at the University of North Dakota has had an outstanding record of encouraging Indian youth to aspire to health professions, to obtain the academic skills necessary to be admitted to professional schools, (especially medical school; and to successfully complete the health professional training and obtain licensure. The INMED approach has stood the test of time and should be supported in other geographic locations.

Advanced Training: While this appears to be an incentive to retention, it is also important to recruitment. A good health professional wants to be a participant in professional training and research; their participation makes them a more competent practitioner. When seeking a practice location, the availablility of this opportunity is a definite plus.

Additional Incentive: Retention Bonus: The pay for providing health services in Indian communities has never been equivalent to that available in most other practice locations and probably never will be. However, the degree to which salaries in IHS fall below those in the private sector has been a serious barrier to recruitment and retention. At some point, the disparity in salaries becomes critical if one is to obtain those practitioners with the requisite skills; both of these important provisions directly address this crucial issue. Providing salaries more competetive with the private sector will significantly improve the ability of Indian communities to maintain their health systems. There may be other mechanisms, such as the Federal Physicians Comparability Allowance Act authority, that could be considered to improve clinical staff salaries salaries but, at the very least, the "incentive special pay" already authorized by statute should be immediately implemented by the Department.

Tort liability: The medical malpractice problem is one facing all communities; the rapidly increased cost of malpractice insurance has resulted in physicians leaving their practices and is resulting in serious shortages of specific specialists (e.g. obstetricians) in some locations as these practitioners discontinue certain services. The high cost of malpractice insurance is also reducing the availability of services in some communities. While the number and cost of malpractice cases has been relatively small in Indian communities, the escalating cost of malpractice insurance has been a serious obstacle for those tribal governments who have chosen to manage their own health programs under the Indian Self-determination Act (PL93-638). Funds which could and should be spent for essential health services have had to be spent for malpractice insurance, if such insurance could be obtained at all. As a result, the level of health care available has been diminished. By including health professionals employed by the tribes under the Tort Claims Act, this barrier to Indian self-determination will be reduced at, if past experience continues, minimal cost to the Federal government.

Foreign Medical Graduate Demonstration Project: In the past, IHS has had some excellent foreign medical graduates (FMGs) and has also had some disappointing experiences. State Boards of Medical Examiners, whose major functions relate to the determination of professional qualifications and competence of physicians, have had a good deal of difficulty in assuring that only physicians with adequate training and competence are allowed to practice medicine in their states. I don't believe it is realistic to expect the IHS, with all of its functions and limited resources, to be able to perform the function that has created so much difficulty for the state boards. Therefore, while it is tempting to look to FMGs to provide relief for the shortage of physicians, my concern for maintaining the quality of medical care in Indian communities leads to my recommendation of caution. The demonstration project proposed in this bill offers, I believe, a reasonable and realistic approach to determine the potential for FMGs in the IHS. If this project identifies a viable way to select those FMGs who could be expected to provide acceptable clinical care at the full physician level, consideration could be given in the future to providing support for FMGs to obtain the required American Medical Association internship or residency in return for obligated service in IHS.

Report on Recruitment and Retention: While I have a long-standing lack of enthusiasm for more studies and reports and believe that action, not study, is the best way to obtain results, I must admit to some interest in this proposal. It offers a unique approach to trying to understand this seemingly permanent, or at least currently unsolved, problem in Indian health. If it was appropriately designed and was carried out with the full participation of all of the involved Federal agencies, including the Office of Management and Budget, it could result in new insights and acceptance of the changes that are required.

In summary, the threat of serious deterioration of the level of health care for Indian communities is real and imminent because of projected shortages of clinical staff; the initiatives in S.1475 offer an immediate and, in my view, the best hope of averting this crisis. While the long-term resolution of the problem of clinical staffing in IHS will require more comprehensive action, the timely passage of S.1475 is essential if the Federal commitment to Indian tribes and the continuation of the remarkable progress already made in elevating the health status of Indian people is to be maintained.

I would be happy to answer any questions that you have for me.

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**STATEMENT OF SUZAN SHOWN HARJO, EXECUTIVE DIRECTOR, NATIONAL CONGRESS OF AMERICAN INDIANS, ON S. 1475, LEGISLATION TO ESTABLISH A CLINICAL STAFFING RECRUITMENT AND RETENTION PROGRAM FOR INDIAN HEALTH FACILITIES, BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS, AUGUST 6, 1987, WASHINGTON, D.C.**

On behalf of the National Congress of American Indians (NCAI), thank you for the opportunity to comment on S. 1475, legislation which would address the critical issues of recruitment and retention of medical personnel for Indian Health Service (IHS) and tribal health facilities. As this Committee knows, the phase-out of the National Health Service Corps (NHSC) will result in only a handful of NHSC physicians being available to IHS facilities by 1990. The NHSC is the source of 70% of the IHS physicians. Compounding this problem is continual battle over IHS Scholarships, with the Administration proposing to fund only existing medical scholarships, and with no new scholarships awarded. We are pleased to note that the FY1988 Interior and Related Agencies Appropriations bill as approved by the House contains $2 million in new monies for a medical student loan payback program and $7.6 million, or $3 million above the Administration's request, for the IHS Manpower Program.

We support S. 1475, and suggest several refinements in the bill and also pose several questions which should be explored as the bill moves toward Committee markup.

We favor the bill's approach of having a loan repayment program specific to people serving in Indian health facilities, and stress the importance of its coordination with

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existing programs. There is, for instance, NHSC reauthorization legislation moving through Congress which also contains a loan repayment program. There also exists a scholarship program administered by the IHS and, as mentioned above, the FY1988 Interior and Related Agencies Appropriations Bill contains $2 million for an IHS medical loan payback program. S. 1475 should be the vehicle to address the gaps and limitations of other programs.

Title I of S. 1475, for instance, requires that in order for a person to participate in the loan repayment program, his or her degree must be in an area deemed to be needed by the Indian Health Service. We believe that the regulations issued pursuant to Title I of the bill should require that the areas of need be based on actual data and tribal assessment, as compared to the rather informal method now used in determining the professional areas in which to award IHS scholarships. The information regarding IHS and tribal health facility needs should be shared and coordinated with any NHSC loan repayment program.

Due to the relatively small numbers of Indian people who are in medical school or who are already medical professionals, the participants in any loan repayment program, even one with an Indian preference requirement as contained in S. 1475 generally will be non-Indians. The proposed loan repayment programs in S. 1475 and the NHCS Reauthorization bill work well with the IHS scholarship program. While non-Indians do receive IHS scholarships when there are insufficient numbers of Indian applicants, the clear emphasis is on offering scholarships to Indian students. With increased recruiting efforts, such as those envisioned in this bill and those currently carried out by Indians Into Medicine (INMED), the IHS scholarship program can serve to bring Indian people into medical professions, while the proposed loan repayment programs can serve to meet immediate Indian health needs by sending trained medical personnel to IHS and tribal health facilities.

Section 104(b) of S. 1475 sets out a formula for the penalty which must be paid by a person who breaks his or her contract with the Secretary regarding obligated service. Basically the person is penalized by paying twice the amount of loan repayed by the U.S. Government minus the time served under the obligation. Under the IHS scholarship program, the penalty is three times the scholarship amount, and still there are companies and communities who, in effect, "buy out" medical personnel by paying the penalty for the physician. We ask the Committee to communicate with IHS on this matter and to assess whether the penalty in S. 1475 should be increased for the purpose of strengthening the disincentive for people to break their medical service contracts.

In addition to the physician supply needed for Indian country, there is a great need for nurses and nurse practitioners. A loan repayment program will be of little help to this category of health providers because they cannot access loans. In the context of this legislation, we urge a special incentive whereby nurses and nurse practitioners can receive loans.

Section 105 of the bill requires a report to be filed every year with Congress regarding the number of health care providers estimated to be needed by IHS for the upcoming three year, and the number of NHSC scholarships and loan repayments estimated to be made in the upcoming three years. Because not all persons who participate in the NHSC scholarships or loan repayment program are obligated to Indian health facilities, we would also request that the report required by Section 105 include the number of scholarships and loan repayment participants obligated to Indian health facilities.

We strongly support Section 203 of the bill which requires that all IHS employees receive instruction in the history and culture of the tribe they are serving and in the IHS history. We believe that a very important aspect of providing good health care and of improving medical personnel retention rates is the appreciation and understanding of the culture of the people the medical personnel are serving. IHS has not placed enough emphasis on this matter, and the health of Indian people has suffered as a direct result. It is important that section 203 be funded.

The tribally-controlled colleges should play a prominent role in the education required of IHS employees under Section 203, in the INMED-type model programs in Section 204 and in the development of demonstration recruitment and retention programs provided in Section 202 of the bill. We are pleased that Section 203 specifically calls for tribal colleges to be utilized in the education process.

The tribal colleges also have a critical role in the area of providing preparatory education for Indian students who wish to pursue health careers and of establishing linkages with health care programs at other universities and colleges. It is very expensive to establish nursing or other health programs, and it has generally been beyond the finanical means of even the most well established and largest tribal colleges to provide such courses of study. The Navajo Community College nursing program ended this year, and both the Sinte Gleska and Oglala Lakota colleges nursing programs have been terminated in the past several years. We note, however, that the program at Oglala Lakota College has now been restarted. All evidence shows that students who attend tribal colleges have a much higher retention rate when they transfer to other institutions and pursue graduate degrees. The tribal colleges are able to provide, among other things, the basic skills, knowledge, direction and self-confidence necessary to successfully pursue careers requiring extensive education.

Tribal colleges in North Dakota, South Dakota and Montana have more Indian students enrolled than do the state colleges in those states. For instance, in Montana there were 690 Indian Full Time Equivalent (FTEs) students at the state colleges and 774 Indian FTEs in the tribal colleges in Montana in 1985-1986. Tribal college graduates have a very high employment rate which is especially impressive when compared against the tribal unemployment rate. Eighty four percent of Oglala Lakota College graduates are employed and another 10% are pursuing further education, making 94% of the graduates either employed or in higher education. The tribal colleges are growing at an average annual rate of 11%, while many other colleges in their states are experiencing declining enrollments. The FY1988 Interior and Related Agencies Appropriations bill, as approved by the House, provides funds for construction of 12 new or replacement IHS hospitals and clinics. These desparately needed facilities will also bring with them the need for medical personnel. This need reinforces our point that the tribal colleges should be able to receive funds to assist in the prepatory and advanced training for the personnel for these new facilities. The new hospital at Rosebud will add 195 positions to the current level of 138, bringing the total of positions at the hospital to 333. The types of personnel needed for just this one hospital are physicians, nurses, laboratory technicians, x-ray technicians, sanitation personnel, dieticians, dentists, dental assistants, pharmacists, physician therapists, respiratory therapists, medical records personnel, health administrators, central supply personnel, and maintenance personnel.

Thus, we request that there be added to Section 204 of the bill which authorizes grants to the INMED program and to two universities for expansion of the INMED model, a new provision which would authorize grants to the tribal colleges under this Section. We suggest the following language in Section 204, after (b), "The Secretary shall make grants to tribally controlled colleges for the purposes of: 1) establishing and maintaining health professional preparatory programs; 2) developing linkages with health care programs at other universities and colleges; and 3) providing outr and health professional recruitment in the elementary secondary schools and in the community."

Thank you for your consideration of our comments.

# ASSOCIATION OF AMERICAN INDIAN PHYSICIANS

## TESTIMONY

before the

SELECT COMMITTEE ON INDIAN AFFAIRS

UNITED STATES SENATE

ON

S. 1475

presented by

**Emmett Chase, M.D.**
**Representing**

**Association of American Indian Physicians**
**National Indian Health Board**
**National Congress of American Indians**

**July 31, 1987**

My name is Emmett Chase. I am an American Indian physician. I am currently the Medical Director for the Compton Urban Indian Clinic in Compton, California. I am also the current President of the Association of American Indian Physicians. I am presenting this testimony on behalf of the AAIP and Jake Whitecrow, Executive Director National Indian Health Board and Chairman of the Health Committee for the National Congress of American Indians. For seventeen years now, the Association has been involved in the development of American Indian and Alaska Native health professionals; physicians in particular. Based on our activities in American Indian health care manpower development, the Association has established itself as a knowledgeable and reliable source of expertise and information regarding American Indian medical and health care issues. I am here today, to talk about a major clinical staffing problem that could have a dramatic affect on the delivery of medical care services to thousands of American Indians.

The Indian Health Service, IHS, is facing immediate and serious problems concerning clinical manpower. According to a recent Special Report, prepared by the Health Program Office of the Office of Technology Assessment, OTA, "the present concern about clinical manpower in IHS is a consequence of changes in the National Health Service Corps, NHSC, the Federal program that since the mid-1970s has provided medical scholarships in exchange for obligated service in health manpower shortage areas." The Report emphasizes that the NHSC is critically important to IHS, "because IHS is dependent on physicians from NHSC to staff its programs." This has been the medical staffing situation for IHS since the termination of the military draft in 1973. Soon after, IHS began to experience a shortfall, as attempts were made to recruit physicians on a voluntary basis. This shortfall was gradually filled through the remainder of the 1970s and the early 1980s by physicians from the NHSC. Members of the NHSC have all or part of their medical education paid by the federal government. In return, they agree to serve a specified period of one to four years at a public or Indian health facility in a health manpower shortage area. During the years 1984 through 1986, the IHS received 130 to 150 NHSC physicians annually. The IHS estimates that it requires 200 new physicians each year to fill vacancies and accommodate growth in its service population. According to the OTA report, "At least 60 percent of new physician recruits, and 45 percent of all physicians working in IHS, are completing their service payback obligations to the NHSC."

Present concern in the IHS stems from the fact that after 1988, very few NHSC physicians will be available. Furthermore, IHS will be competing with other public health providers, such as community health centers and migrant health centers, for these few physicians. Less than 500 NHSC physicians will be available in 1988, after which, only 320 physicians will be left in the NHSC pipeline. Although there exists an Indian health manpower training program, which may provide IHS with about 15 service-obligated physicians a year for a few years, new scholarships in this program are also being phased out.

Beginning in 1980, when the Reagan Administration assumed office, a concerted effort has been made to terminate the NHSC program. The Administration's rationale for this effort was based on their belief that it was no longer needed because a surplus of physicians nationally "will diffuse to provide services to underserved populations." There now seems to be a general consensus that there is an oversupply of physicians in the United States. Because of this oversupply of physicians, particularly in metropolitan and suburban areas, the Administration predicts that new physicians will be forced to locate in rural communities and inner cities in order to make a living. Thus, the need for NHSC physicians to serve these populations will be eliminated. There are significant problems with this prediction for the Indian Health Service and Indian people, particularly those residing on or near Indian Reservations.

First of all, many Indian Reservations are located in some of the most isolated and least desirable areas of the country. Second, it is not possible for private physicians to establish private practices on Indian lands, and finally, physicians would have to be employed by the IHS in order for eligible Indians to use their services without charge. The OTA report emphasizes:

> ". . . a national physician surplus will improve medical manpower and services for Indians only if it greatly increases recruiting of voluntary physicians into IHS, which does not seem likely in the near future, given the other organized practice alternatives available to physicians, the undesirability of many IHS sites, and uncompetitive IHS salaries and benefits."

In recent months, several U.S. Senators have indicated their concern by taking an active interest in this problem. Perhaps one of the significant actions to date has been the introduction of a bill by Senators Melcher, Inouye, Burdick, that would address the IHS clinical staffing problem. The bill, introduced as S. 1475, has received broad support, including that of Indian Tribes and Indian organizations such as the Association of American Indian Physicians, AAIP. The AAIP has reviewed the bill and supports many of the activities outlined but offers the following recommendations to enhance the overall purpose of the legislation.

TITLE I, Sec. 101, Part (b) - Eligibility to participate in the Loan Repayment Program.

Under paragraph (1), specifying that an individual "be enrolled as a full-time student and in the final year..." This paragraph should require that a student must have been enrolled as a full-time student in an accredited institution in the past. An individual should be able to demonstrate successful completion of a program leading to a professional degree. This would insure that an individual would be immediately available for service rather than waiting for completion of the program. The same stipulation should be made for paragraph (2) for graduate programs. Paragraph (3) should add that an individual should achieve board eligibility/certification in a medical specialty or be certified in an allied health profession prior to loan repayment. This again would help to insure the maintenance of higher quality health care delivery to American Indian people.

TITLE II- OTHER RECRUITMENT AND RETENTION PROVISIONS

A section should be added that addresses the problem of impaired providers as a quality assurance and retention strategy.

Sec. 205, paragraph (a), which calls for "advanced training or research". Clarifying language should be used in stipulating that research activities be directed toward elevating the health status of American Indians.

Sec. 208, Foreign Medical Graduate Demonstration Project - This provision raises some serious concerns with the AAIP. If this provision is to be adopted, the target group of health professionals should be foreign trained Americans. We should not encourage the immigration of foreign nationals that might result in a significant shortfall of health providers in their own country. In addition, it is generally conceded that there are significant cultural barriers between white American society and Indian people which at times impedes effective delivery of quality health care to Indian people. We feel that the importation of foreign nationals into the IHS will only make this problem worse.

Sec.209, paragraph (a),(1) - Preference for service on this advisory panel should be given to American Indian physicians or other Indian health professionals.

A new section should be added to include a comprehensive analysis of attitudes of health professionals that affect retention in the IHS. This analysis should include a special review of the recruitment and retention efforts made in regard to Indian health professionals.

**INDIANS INTO MEDICINE**

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# STATEMENT ON THE IHS RECRUITMENT AND RETENTION BILL

(S. 1475)

presented by

GARY FARRIS, DIRECTOR

INMED PROGRAM

before the

SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

UNITED STATES SENATE

AUGUST 6, 1987

THE UNIVERSITY OF NORTH DAKOTA

AN EQUAL OPPORTUNITY INSTITUTION

Thank you for the opportunity to appear before you. My name is Gary Farris. I am a Cherokee Indian, and the Director of the Indians Into Medicine program at the University of North Dakota.

I am here on behalf of INMED and its tribally-appointed Board of Directors, to speak to you regarding the Indian Health Service Recruitment and Retention bill (S.1475). Title II of the bill contains provisions which would maintain the current INMED program and establish and maintain new centers at a minimum of two additional institutions.

Thank you for recognizing the value and effectiveness of the program. I am enthusiastic about expanding INMED to include satellite centers at other institutions, to be determined by a competitive grant award process.

INMED is a comprehensive student recruitment and support program which began in 1973 as a means of providing Indian health professionals to meet Indian health needs. The program began operation at a time when the supply of physicians entering IHS practice was dwindling due to the termination of the federal doctor draft program. Through the doctor draft, IHS service was a possible alternative to military service for doctors.

The need for INMED is underscored once again in 1987 with phasing out of the National Health Service Corps scholarship program. Indian health care will face severe manpower shortages, both in the near and in the distant futures.

The loan repayment program authorized by Title I of S. 1475 will provide health professionals for IHS facilities at a time when IHS facilities suffer the initial effects of the loss of NHSC doctors, and will establish a partial supply of IHS doctors into the future.

We are particularly encouraged by the farsightedness of the S. 1475 sponsors in including provisions to increase the numbers of Indian health professionals, particularly through expansion of the INMED program. INMED is designed to provide well-qualified Indian health professionals to meet Indian health needs. Indian health professionals will be generally more aware of Indian health needs, more committed to long-term practice among Indian people, and will possess a greater understanding of patients' cultures and needs.

We strongly recommend that an expansion of the INMED program should be accompanied by an increase in the number of IHS scholarships to meet the financial aid needs of the additional Indian health professional students.

According to Congress' Office of Technology Assessment statistics released last year, the IHS physician-to-population ratio in 1984 was 0.7 physicians per 1000 population. For the U.S. population as a whole, the ratio was 1.65 active, non--Federal patient care physicians (1980) per 1000 population.

INMED is already having a national impact on Indian health manpower needs. The program has assisted a total of 75 Indian health professionals during their educations, including 53 doctors of medicine. All of the INMED physicians have graduated since 1976, for a rate of five M.D.'s per year.

Each year INMED recruits from a pool of potential Indian health professionals, and provides comprehensive academic and personal support for over 80 fulltime college and medical students. Another 70 junior high, high school, and pre-medical students participate each summer in special enrichment sessions. Students can become involved in INMED's support program as early as the junior high school level and participate until they earn their health professional degrees. These summer enrichment sessions are vital to establishing a pool of potential college students, and preparing them for health careers curricula.

The importance of the comprehensive INMED approach cannot be overlooked, because it has proven to be substantially more effective than piecemeal minority programs.

Reservation Indian students, with INMED's consistent support, maintain sight of their career goals and earn their degrees, as indicated by the program's annual retention rate of 85% for undergraduate students and 90% for medical students. Alexander W. Astin's "Minorities in American Higher Education" statistics indicate a national retention rate of 40% for Indian students generally.

During their careers, INMED graduates will repay the federal investment in their educations through federal income taxes, while other reservation Indians face unemployment rates of 50% to 90%. The program has also been studied by representatives of the Canadian and Australian governments.

INMED currently supports students seeking degrees in medicine, nursing, medical technology, optometry, and health administration.

INMED's affiliation with IHS is fundamental to the program's effectiveness. We at INMED welcome the opportunity to assist in the development of similar IHS-funded INMED programs at other campuses.

The name INMED is well-known in Indian communities, and represents the noble and attainable goal of Indian people meeting Indian health needs. This established relationship between INMED and Indian populations through our Board of Directors is also fundamental to the program's effectiveness.

Nationally, the numbers of Indians entering the highest health professions is decreasing. Association of American Medical Colleges statistics indicate that American Indian/Alaskan Native applicants represented less than one percent of medical applicants in 1985. In absolute numbers, there were 125 Indian applicants to the 1985-86 entering class, a decrease from 150 the previous year. The number of acceptances decreased from 72 to 55.

The reservation to university transition is difficult. At UND we have established a recruitment and support network geared toward perseverance and goal attainment. INMED is a source of pride not only for IHS and the Indian community, but also for the university. The UND School of Medicine has added five slots in its entering class each year specifically for INMED students.

The university administration and faculty are supportive of INMED students, as evidenced by students' clinical experiences at

IHS sites and the developing of individualized curricula as necessary. I am optimistic that similar commitments can be secured from receptive colleges and universities in other Indian health manpower shortage areas.

Once again, I thank the sponsors of S. 1475 for recognizing the importance, stability, and success of INMED, and for initiating its expansion. My staff and I look with enthusiasm toward the opportunity to share the benefits of our 14 years of program development with satellite INMED centers. I firmly believe that the Federal support to establish new INMED programs will be echoed by appropriate health education institutions, and also by under-served Indian communities in other geographic areas.

# STATEMENT OF

EVERETT R. RHOADES, M.D.

DIRECTOR

INDIAN HEALTH SERVICE

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS

U.S. SENATE

AUGUST 6, 1987

Mr. Chairman and Members of the Committee:

I am Dr. Everett Rhoades, Director of the Indian Health Service (IHS). I am pleased to be here today to discuss with you S. 1475, a bill which would address some of the problems associated with recruitment and retention of health personnel within the IHS.

We recognize certain recruitment and retention problems at the Indian Health Service and we are already carrying out a number of actions to alleviate these problems. Although some of the provisions in S. 1475, such as the loan repayment program would address IHS personnel requirements, other provisions raise numerous problems regarding civilian and uniformed services personnel systems. We object very strongly to the bill's provisions establishing or applying new incentives for General Schedule personnel in the Indian Health Service that are not generally applicable to Federal civilian employees. As a result, the Administration cannot support S. 1475 in its present form.

In Senator Melcher's statement on July 9, introducing S. 1475, he noted the recent special report of the Office of Technology Assessment (OTA) on "Clinical staffing in the Indian Health Service," and indicated that this bill was intended, at least in part, to implement recommendations made by OTA. Dr. Robert E. Windom, Assistant Secretary for Health, Public Health Service (PHS), testified on April 30 on the OTA report before the House Committee on Interior and Insular Affairs. In his testimony, Dr. Windom noted that the report clearly presents the current situation in IHS. He also pointed out that while the problem is one of recruitment and retention of physicians in the Indian Health Service, it is linked also to the broader problem of availability and distribution of health professionals.

In addition, Dr. Windom described some of the efforts that are already underway in IHS to deal with health professionals recruitment and retention. In summary, the IHS has developed a recruitment plan in conjunction with the Health Resources and Services Administration (HRSA) to provide health professionals for underserved areas, including the IHS. The plan includes funds for clerkships, journal ads, conference displays, site visits, and prospective candidate travel. Additional initiatives include a Medical School Advocate Program, a long-term training program for residents, and development of a recruiting videotape. As you can recognize, much effort is already being expended, though much remains to be done.

In addition to these various individual activities aimed at improving IHS recruitment and retention of health professionals, I would also like to underscore the PHS Commissioned Corps revitalization now underway. Surgeon General Koop has implemented this revitalization with the goal of making the Commissioned Corps more effective. An important component of this plan will be to increase the mobility of the over 5,000 Commissioned Corps health professionals, many of whom already serve in the IHS. As noted in the recent OTA report, the PHS Commissioned Corps is an elite mobile force whose officers are subject to reassignment to meet public health needs and emergencies. We anticipate that the revitalization underway will greatly enhance our ability to strengthen placement of additional Commissioned Corps officers in IHS priority locations.

S. 1475 would authorize a loan repayment program permitting IHS to recruit individual health professionals, including students in their final year of professional school. In exchange for a period of obligated service, IHS would be required to repay a certain amount of the students educational loans. Other provisions of the bill would also authorize grants for tribal demonstration projects in recruitment and retention; require training in Indian history and culture to IHS clinical staff; maintain and replicate the Indians into Medicine Program (INMED); provide various incentives for existing clinical staff to stay with IHS; require IHS to investigate the possibility of using foreign medical graduates as physician assistants; and establish an in-house review panel to evaluate IHS policy and procedure impacting on recruitment and retention.

As expressed in a July 9, 1987, letter from Secretary Bowen to the Chairman of the Senate Labor and Human Resources Committee, we believe that a loan repayment program would be an improvement over the current scholarship program of the National Health Service Corps. We believe that such a program makes good sense and would help address the unique recruitment needs of the IHS. Unlike scholarship programs, a loan repayment program could provide health professionals quickly to help fill vacancies in the IHS and would provide a timely, effective, and economical means of recruiting health professionals for service to meet priority needs, while allowing maximum flexibility in targeting the program from year to year.

Section 201 would authorize IHS to use funds to pay for spouse travel, when the spouse is accompanying an applicant for an IHS position to his/her prospective employment site. No other prospective Federal employees are granted spouse travel benefits, and we believe this provision would create an undesirable potentially costly precedent.

Section 203 would require all employees serving specific tribes to receive instruction in the history and culture of such tribes. Instruction would, to the extent feasible, be under the auspices of the tribes served. We favor increased participation of tribal governments in recruitment and retention efforts and make efforts to orient our employees to the culture of the tribes that they serve. However, we believe that the aspect of making instruction mandatory might be viewed by some as a disincentive to recruitment.

Section 204 would require IHS to maintain the INMED Program at the University of North Dakota and to replicate the program at a number of other schools through a competitive grants process. More study should be undertaken before replication in other, often different, environments should be legislated. The proposal does not adequately describe what it is that should be replicated. In addition, it would be inconsistent not to require INMED also to compete. Based on INMED's experience, it would have no problem competing for its grant in the future. Also, we do not believe separate regulations should be required, but rather that reliance should be placed on grant regulations that are in place.

Section 205 would establish a program to support advanced training and concomitant research at medical schools for IHS staff. The IHS existing recruitment plan already allows for allocating increased resources for continuing medical education. In addition, each year residency training in family medicine and other selected specialties will be sponsored by IHS for Commissioned officers. Current officers will be given preference for residency training in order to improve retention. Once the training is completed, these physicians will be assigned to hard-to-fill sites as determined by the IHS. This program is in its first year. We plan to select up to 25 physicians for this program in 1987, 12 of whom were select on April 15 of this year. Since present training requirements for Civil Service employees limit long-term training to 2 years, section 205 would equalize the opportunity available to employees in both systems and provide additional flexibility by allowing longer residencies for Civil Service employees.

Section 206 proposes various "Additional Incentives". PHS statutory authorities currently permit the PHS to establish "incentive special pay" for medical officers serving in the Commissioned Corps. Section 206(a) would mandate use of, and expand this authority to include Civil Service medical officers in IHS and requires its implementation for hard-to-fill locations or shortage specialties. As Assistant Secretary for Health Windom previously testified, implementation of "incentive special pay" for Commissioned medical officers serving in hard-to-fill IHS assignments or who have specialties for which the IHS has a difficult time recruiting, e.g., orthopedics, ENT, radiology, urology, and child psychiatry, is under active consideration, but for pay to Commissioned Officers, not to civilians who are not covered by military pay laws.

Since HHS already has authority to grant incentive special pay, and is currently examining this matter, there is no need to statutorily require payment of a bonus. It is important to maintain administrative flexibility in personnel matters, and we believe that the incentive bonus should remain discretionary. The differing purposes and requirements of the uniformed and civil services necessitate differing personnel policies for the two distinct systems. It is inappropriate to merge or mix these two systems. Any deficiencies in the civilian personnel system should be corrected through that system.

A more appropriate vehicle for providing bonuses to address the recruitment and retention problems in the IHS is the Physicians Comparability Allowance (PCA), scheduled for reauthorization this year. As of March 31, 1986, 85 civilian IHS medical officers were already receiving physicians comparability allowances. The Department believes that the PCA should be reauthorized, and that the current $10,000 ceiling on this bonus payment, which has declined in value since its enactment in 1978, should be increased. The Administration will soon advance reauthorization legislation for the PCA to the Congress, proposing that the ceiling be raised to $20,000 as we have recommended.

Section 206(b) would establish an incentive bonus with a maximum of $2,000 for designated IHS health care professionals other than medical officers. In addition to the problems noted above, we do not believe the bonuses are either necessary or justified for use except as already authorized for physicians. Moreover, section 206(c), requiring the Secretary to establish a flexitime program, when flexitime is already allowed, is unnecessary. Section 206(d), providing for unlimited overtime for professional health care employees, is inappropriate and costly.

Section 207 creates yet another new retention bonus for both Commissioned Corps and civilian IHS employees, and sets a $12,000 floor on annual bonus payment to individuals. The criticisms of new bonuses stated earlier are equally valid here, but let me reiterate that it is important to maintain the distinctions between the uniformed and Civil Service systems. Moreover, while some change in the health professional compensation system may be necessary, the PCA is the appropriate mechanism for addressing the issue, not the creation of yet another special bonus. Even if a new bonus were warranted, a $12,000 per annum floor is excessive and could inappropriately give additional pay to IHS staff not in a position with a recruitment or retention staffing shortage.

In summary, we strongly oppose the miscellaneous array of bonuses and special pays proposed in S. 1475. The title 5 special rate authority already available to IHS, and the Administration's proposed Civil Service Simplification Act proposal, introduced as S. 1545, would, for instance, permit special rates on the basis of undesirable geographic location, something which would be particularly valuable to IHS for both physicians and non-physicians.

We also oppose section 208, which would establish a limited demonstration program to investigate the possibility of using foreign medical school

December 21, 1972, to December 5, 1979. This latter date is the date of passage of the Indian Civil Service Retirement Act, Public Law 96-135, which made Indian preference applicable to reduction in force and, therefore, changed the conditions of employment applying to non-Indians in these agencies who were appointed before the date of enactment. We are considering the impact of this provision on our agency; the Department of the Interior is doing likewise. We will be happy to advise the Committee as soon as we have developed a position on this section.

Section 211, as provided with your letter of invitation, would extend medical malpractice coverage of the Federal Tort Claims Act (FTCA) to cover certain Indian contractors. The IHS is undertaking a study of the number of medical malpractice suits filed against tribal organizations contracting to carry out IHS functions under the Indian Self-Determination Act and the cost of malpractice insurance paid for out of IHS contract funds. We will be happy to share this study with the Committee when it has been completed.

That ends my prepared statement. We will be happy to attempt to answer any questions you may have.

AMERICAN NURSES' ASSOCIATION
WASHINGTON, D.C.

# TESTIMONY

of the

AMERICAN NURSES' ASSOCIATION

on

CLINICAL STAFFING IN THE INDIAN HEALTH SERVICE

Before the

SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

Presented by

ALBERTA BOYLE, R.N., M.S.

AUGUST 6, 1987

1101 14th STREET, N.W., SUITE 200, WASHINGTON, D.C. 20005 — 202-789-1800

Mr. Chairman, I am Alberta Boyle, RN, MS; and am presently a doctoral student at the University of Oklahoma. I teach psychiatric nursing at Oklahoma City University and am a Native American nurse of Chickasaw-Choctaw descent. I am an American Nurses' Association (ANA) minority fellow, and during my tenure as a 1987 minority legislative intern I worked with Dr. Faye Abdellah, Deputy Surgeon General and Chief Nurse of the Public Health Service.

I would like to thank you on behalf of the 188,000 members of the ANA and its 53 constituent state nurses' associations for this opportunity to address the issue of clinical staffing of the Indian Health Service (IHS).

Nurses are a vital resource in providing access to essential health services for all population groups. ANA believes nurses are especially vital in assuring that underserved minority populations receive necessary health care and utilize and participate in the health care delivery system.

We would like to commend the committee for recognizing the critical issue of clinical nurse shortages that S. 1475 addresses. We also applaud Senators Inouye and Burdick for their commitment to nursing and their recognition of the importance of nurses in the provision of essential health care services to underserved populations.

## Indian Health Service

IHS has the responsibility of providing comprehensive health care to American Indians and Alaska natives who are eligible for Federal services. In 1987 the IHS-eligible service population includes nearly one million people.

IHS administers a large community health and medical care program. It operates 51 hospitals, ranging from 6 beds to 183 beds; 99 health centers, including school health centers; and 108 health stations. These facilities are located in 24 states, including Alaska, with the majority located west of the Mississippi River. Nurses provide a major portion of this health care.

The goal of the IHS has been stated as optimal health for the American Indian and Alaska native populations. However, the Administration has repeatedly proposed cuts for Indian health care. One of ANA's major goals is to improve access to care for underserved and at risk populations. Accordingly, we are distressed at the Administration's lack of good faith commitment to Indian health.

Despite progress in America's health care, Indians still live in an environment characterized by inadequate and understaffed health facilities, improper or non-existent waste disposal and water supply systems, and continuing dangers of deadly or disabling disease. The following facts still remain true in the world's most progressive nation:

- The incidence of tuberculosis is 4 to 6 times higher for American Indian and Alaska natives than for the total U.S. population.
- The rate of diabetes is at least 3 times as high.
- The birth rate is 2 times the general population rate.
- Maternal mortality is 7.6 compared to 8 for the total population.
- Suicides for ages 15-24 are the second leading cause of death after accidents and are more than 2 times the figures for the total U.S.
- Respiratory disease, otitis media, cholecystitis, and venereal disease - are all significantly higher in the native American population.
- Life expectancy for the average American is 74 years while the

> Indian and Alaskan native life expectancy is 71.1 years.
>
> The prevalence of alcohol use and abuse can be attributed to four of the top ten leading causes of death among native Americans i.e. accidents, suicides, homicides, and liver cirrhosis. Liver disease and cirrhosis death rates in 1980-82 were 4.2 times that of the U.S. general population.

However some statistics have improved. For instance, infant mortality has decreased from 1.1 times the national average to .9.

My own experience in psychiatric nursing has encouraged me to recognize and evaluate the problem of alcoholism as it exists among native Americans. Frequently alcohol is seen as a prominent factor in family violence, abuse and neglect. Children from such environments are denied the experiences necessary for healthy growth and often develop substance and alcohol dependencies of their own. They may abuse or neglect themselves and others, have low educational achievement, express themselves through delinquent behavior and anger, and are most likely to commit suicide. On a large scale, this leads to cultural disintegration, oppression, and powerlessness. While the need for alcohol treatment programs which focus on primary prevention, early identification and treatment is greatest in the remote areas of the reservations, statistics and testimonies indicate that intervention in every community is warranted.

IHS is the largest direct delivery system in the U.S. Department of Health and Human Services (HHS). In 1985, IHS employed about 750 physicians, 2,000 registered nurses, 800 practical nurses, 300 pharmacists and 275 dentists. Unfortunately this work force is thought to be 10 to 20 percent short of what IHS believes it needs to deliver its present level of services. As such, clinical staffing as it now stands for Indian Health Service facilities is clearly inadequate for high quality health care. A recent congressional Office of

Technology Assessment report predicts a crisis in staffing, forcing the IHS to further reduce or eliminate services. Findings indicate that the IHS is experiencing critical problems in recruitment and retention of qualified nurses. As of August 1, 1987, IHS has 2,075 permanent registered nurses, with 260 vacancies. This is more than a .3 percent increase in vacancies since 1985. A breakdown of those numbers indicates an overall nurse shortage in the following areas:

Oklahoma and Alaska - 8%
Navajo - 21%
Albuquerque - 16%
Aberdeen - 12%
Tucson - 17%
Bemidji - 12.5%

These figures demonstrate severe deficiencies in the ability of IHS to provide health care to those native Americans. While the Navajo has an overall nurse shortage of 21 percent, it has a 24 percent shortage of staff nurses. Aberdeen is the worst notwithstanding the 12 percent figure because positions are being staffed with temporary nurses.

These shortages are attributed not only to lack of professional people, but also geographical area and lack of money to recruit effectively. Recently the Navajo lost a much needed nurse supervisor to the school system. Imagine that, a public school system which can pay a nurse more than a federal agency. A recent college graduate who was excited about possibly working for IHS turned down a job offer when told the salary.

## Nursing Shortage

Nurse staffing problems are not limited to the IHS. According to data released by the American Hospital Association in January of this year, the vacancy rate for registered nurses in U.S. hospitals has more than doubled between 1985 and 1986, up from 6.3 percent to 13.6 percent. The shortage of registered nurses is widespread and particularly acute in the Middle Atlantic, Pacific, and East North Central regions of the country. The current nursing shortage could prove to be a complex and long-range problem. HHS predicts a 40 percent undersupply of nurses by 1990.

Recent reports of unfilled positions in hospitals and a more thorough analysis of the situation show that the marketplace for registered nurses is changing in response to recent developments in health care delivery.

- The number of unfilled positions, particularly in specialty practice requiring advanced education and skills, has increased. This is the result of increased acuity of hospitalized patients and changing demographics, particularly the rising numbers of older Americans. While graduations from nursing education programs have continued to rise, new graduates cannot be expected to immediately function in highly specialized practice areas.
- Increased patient acuity and earlier discharges (the "quicker and sicker" phenomenon of the prospective payment system) have resulted in an increased workload per registered nurse. Because there has been no corresponding increase in pay and benefits accompanying the increased workload, recruitment and retention of nurses, particularly in specialized practice areas, is becoming more difficult.
- More baccalaureate prepared nurses are needed. Baccalaureate-prepared nurses are the ones most qualified and most likely to move into specialty areas, such as critical care. HHS predicts a 40 percent undersupply of baccalaureate-prepared nurses by 1990.
- The registered nurse population is approximately 97 percent female.

Since career opportunities for females have multiplied in recent years, it is more difficult to recruit young graduates into nursing. This shift of the female high school graduates to other career choices is substantiated by recent declines in nursing school enrollments.

- Competition in the new health care marketplace has produced a wide array of expanding career opportunities for nurses such as health maintenance organizations, home health agencies, hospices, risk management centers, and entrepreneurial activities. Experienced registered nurses are leaving their positions in institutions to explore these opportunities, which in part accounts for the unfilled positions in hospitals.

## RN DATA

| | |
|---|---|
| Total RN population: | Nearly 1.9 million (1,887,697) |
| Percentage employed in nursing: | Nearly 1.5 million (1,435,725) or 78.7% of the total - up from 76.6% in 1980 |
| Annual average salary of Registered Nurses: | $25,500 - $26,000 |

## BASIC NURSING EDUCATION PROGRAMS

1985 preliminary data compared to 1984 data:

| | |
|---|---|
| Baccalaureate Degree | enrollments down 4.2%<br>graduations up 1.8% |
| Associate Degree | enrollments down 7.8%<br>graduations up 1.8% |
| Diploma | enrollments down 19% |

graduations down 2.5%

Preliminary 1986 data indicates a deeper decline
in fall admissions and enrollments.

Nursing is one of the most sex-segregated job classifications in the country. As noted previously, approximately 97 percent of all nurses are women. Nursing has traditionally been viewed as women's work and, as such, has been undervalued. The result is salary compression, i.e. there is only a minimal difference between the $20,340 starting salary for a staff nurse employed by a hospital and the average maximum salary of $27,744. Given the skill, effort, responsibility, and working conditions of nurses, such compensation is neither attractive enough to lure new recruits, nor competitive enough to retain nurses with years of experience.

The American Nurses' Association is concerned about the unfilled positions created by the change in demand in the health care marketplace. The association is committed to assuring that the high quality of health care is maintained, and that there is an adequate supply of well-qualified registered nurses to meet the changing demand in the private sector as well as the IHS.

The recruitment and retention of nurses at individual hospitals is only part of the problem. For the first time, almost 80 percent of all nurses are employed. As we have stated, declining student enrollment increases the problem. Therefore, to increase the pool of nurses available for employment, more individuals must enter the profession. The IHS will not be able to recruit or retain a non-existing professional.

The 1983 IHS recruitment and retention study made several recommendations to correct recruitment and retention deficits of nurses, and many are still applicable. We will address several of these: competitive salaries; benefits;

and tuition reimbursement. We will also discuss the vital necessity for nursing participation in executive decision-making in planning, policy development, and budget activities throughout the IHS. Uniformity and consistency regarding the inclusion of nursing should occur at the IHS and at its individual facilities.

The nursing shortage threatens to involve all types of nurses, in a variety of clinical settings, and in all regions of the country. Therefore, it will present staffing difficulties for our health care delivery system in its entirety.

However, this situation would appear to be most problematic for the Indian Health Service, as a nursing shortage compounds the recruitment and retention difficulties that it is already experiencing with health professionals in general. The fact is that problems associated with the recruitment and retention of nurses, specifically, continues to multiply in IHS. The vacancy rate for staff nurses is 12.5 percent for GS 4-9 positions and the turnover rate has been as high as 39 percent. Computations show that the replacement costs for nursing staff who have quit run $1,950,965 per year. Therefore, IHS is losing money by paying nurses less, and the ability of IHS to attract qualified nurse candidates is greatly diminished.

IHS must be able to compete with the local market for nurses to fulfill its congressional directive to raise the health status of all. Unfortunately, the nationwide nursing shortage will make this already difficult task, of recruiting and retaining qualified nurses, even more problematic. The sad fact is that although nurses are being under-paid, the IHS nurse earns even less than the non-federal nurse. More than half of the IHS job offers are turned down by applicants, and the quit rate is excessive at 22 percent.

Nevertheless, nursing remains a vital and integral part of the Indian health care delivery system and nurses frequently take on an expanded role. Nurses play a major role in the assessment of the population's needs in all aspects of the community. The work of nurses within the IHS covers a complete range of health services including, but not limited to, the assessment of patient and family needs; the evaluation of treatment and care and the modification of that care so that it best meets the individual's needs; the planning of present and future care; the performance of necessary routine procedures; and the teaching of both health maintenance and promotive health behaviors. Utilizing a holistic approach to health care, nurses within the IHS help to give their patients a sense of self-control, and encourage them to actively participate in the achievement and maintenance of their own well-being. Nurse practitioners, who are registered nurses who have acquired the additional education necessary to provide a wider range of health services, also practice within IHS. Like all registered nurses, they emphasize health promotion and disease prevention. In their roles as primary health care providers their functions include physical examination, use of laboratory data, determination of routine illness, prescription of medications as allowed by State laws, and referral when necessary. Certified nurse midwives and nurse practitioners improve the accessibility of health care services and in doing so provide a most valuable service to IHS, especially at this time when IHS is experiencing a diverse health manpower shortage.

Nursing is clearly essential to the IHS and is instrumental in the provision of a wide range of quality health care services to the populations served. Consequently, a nursing shortage is detrimental to the health of these native populations. A number of IHS hospitals have been closed temporarily. Some IHS hospitals have been forced to close units and others have had to hire nurses from temporary employment agencies. Even those hospitals which are administered by the tribes continue to experience shortages.

An additional problem is the availability of monies to fund full time employee (FTE) positions. Although we talk about present shortages in our testimony they refer to funded nurse positions. However it is understood that even more nurses are needed. Ellen Smith, Office of Technology Assessment, in her April 30, 1986 testimony before the House Committee on Interior and Insular Affairs indicated that a special IHS task force in 1986 projected a need to recruit 650 nurses per year to maintain present IHS staffing levels.

In his testimony of April 2, 1987 before the Interior Subcommittee of the Senate Appropriations Committee, Dr. Rhoades, Director of IHS, indicated that although two new hospitals were due to open, adequate staffing with present FTE budgets would be difficult. In response to questions as to how he would accomplish it, he stated staffing would be phased in to allow the opening of the facilities after examining priorities. Although we recognize Dr. Rhoades' dilemma, we do not believe such a feat is possible. Clinical staff cannot be split down the middle nor is it yet possible to clone them.

IHS has recently reported 39 cases of AIDS. The disease has also been linked with the increasing suicide rate among native Americans. If AIDS affects this population as it does other minorities in the U.S., there will be an additional need for more nurses to provide care for its victims. AIDS is a nursing intensive disease. It requires nursing care in the hospital, at home and in hospice settings. The psychological and emotional effects on the patient, family, friends and community also require nursing intervention. Studies show that AIDS patients require almost double the nursing care that equally ill patients without AIDS require.

If the number of adequate qualified nursing staff at IHS remains at the current level, it will have a truly devastating effect on the present and future health status of American Indians and Alaska natives.

Loan Repayment Bill

S. 1475 is a bill to establish an effective clinical staffing recruitment and retention program for the Indian Health Service. ANA has reviewed S. 1475 and believes that the Chairman, and Senators Melcher and Burdick have taken a comprehensive and commendable approach to the development of the proposed clinical staffing recruitment and retention program and loan repayment. We have some concerns about certain aspects of the bill but endorse it nonetheless. We offer the following comments and recommendations for the committee's consideration.

This bill begins to address the problem of nurse recruitment, as experienced by IHS, by focusing on how to encourage health care professionals to join the Indian Health Service. By establishing a program to be known as the Indian Health Service loan repayment program, the bill attempts to deal with the pressing registered nurse recruitment and retention issue by providing an attractive loan repayment mechanism to encourage registered nurses to join the IHS. Although the loan repayment program applies to a broad range of health care professionals and allied health professionals, ANA is concerned that the need for nurses could be overshadowed by the need for physicians. We have seen such practices occur in other Federal agencies. A real commitment to correcting the nursing shortage in IHS must be communicated to the Secretary of HHS so that nurses and other non-physician providers can have equitable access to loan repayment funds. Without such direction in Section 101(f)(i) of the bill, the bias toward physician applicants may be repeated within IHS. This is especially important in light of the exclusion of nurses from the National Public Health Service Corps scholarship program.

We would also suggest that Section 103(b)(4) be expanded to include a subsection (D). That subsection would refer to an individual in nursing who is completing advanced clinical education or training to specialize, for example, as a nurse midwife, community or public health nurse, nurse practitioner, or clinical nurse specialist and would be similar to that provided in Section 103(b)(4)(A) for doctors. Such nursing specialties are critical for those who provide care to an underserved population, and are vital to the correction of the dismal health statistics outlined earlier. ANA does not believe that Section 103(b)(4)(B), which applies to nurses, would allow for a deferment of obligated service. Applicants for such specialties would have already completed their academic training to become a registered nurse and would therefore be subject to rendering obligated service without the suggested amendment.

While the bill attempts to deal with the nurse staffing issue, a second look would have one realize that it does not adequately address what is perhaps the most urgent problem of all, staff retention. While it is encouraging to find that this committee is seriously exploring the recruitment issue and searching for a practical solution, the ANA believes that it is of equal importance to also investigate those factors which most often have an impact on nurse retention. We believe it is necessary not only to seek out ways to attract new registered nurses, but also to search for ways to keep present nursing staff. Otherwise new recruits may leave IHS after their period of obligated service has terminated.

In a 1983 study of registered nurses in the Indian Health Service which looked at factors influencing recruitment and retention, it was reported that two of the most important measures that IHS could take to improve nurse retention would be to increase salary and fringe benefits, and improve training and career development opportunities. Those same measures are applicable today as well.

The issue of salary was alluded to earlier, but as it is an important concern, the issue will be re-examined. Studies indicate that we are on the verge of a major nursing shortage which is expected to affect all nursing disciplines in a variety of clinical settings throughout the country. If the Indian Health Service hopes to compete with the private sector for registered nurses from a diminishing market pool, then it will have to make its salaries competitive with those offered by the private sector. This must include increasing the starting salaries for registered nurses; upgrading or applying special pay to those nurses above GS-9; making pay and benefits equal for all personnel systems; accelerating salary increases; and offering monetary incentives for performance, retention, or for nurses who practice in remote areas.

Professional education, training and career development is a large component of nursing practice. It is necessary to maintain competency and to improve skills. As such, improved and equitable opportunities for continuing education, short and long term training, and staff development should be an integral part of existing nursing programs within IHS. However, when surveyed, registered nurses practicing within IHS were dissatisfied with their opportunities to improve and maintain their skills and knowledge through existing continuing education programs. When asked for ways to improve continuing education, the IHS nurses universally responded "increase funding!" Approximately $100-$200 per RN per year is available for short and long term training programs. We believe that $500 per RN per year is more reasonable in light of the increased cost of both educational resources and programs. A need was also expressed for tuition reimbursement programs to promote staff development. The benefits of tuition reimbursement are two-fold. First, it would allow for the establishment of a clinical ladder in nursing practice. Second, it would also provide IHS with a means to produce its own nurse clinicians, nurse practitioners and nurse administrators. The professional practice level in the private sector for community and public health nurses is a masters in nursing. IHS has very few masters prepared nurses, Indian or non-Indian. Such development is necessary if the agency wants to provide quality health care. It is mandatory if we want to improve the appalling earlier health statistics. Present staffing cannot assure that. We would like to see a decrease in young suicides that parallels the one seen in infant mortality. The presence of these nurse professionals helps to effectively provide and direct the provision of essential nursing care. Their expertise prevents the emergence of a second class system of health care for native Americans.

Health care providers from many professional groups have noted that the single most important aspect of providing health care to cultural minorities is to educate health professionals who share the culture and language of the client. This same statement can be made about nursing. Nursing care that is responsive to cultural differences requires a knowledge of that culture. It also requires the integration of cultural minority nurses into the health care delivery system through increased education and training.

To provide nursing care which is sensitive to the specific cultural needs of native Americans, and to achieve the ultimate goal of Indian self-determination, it is necessary for IHS to launch a major recruiting effort which would target the American Indian and Alaska native populations.

Although the Indian Health Scholarship Program has been somewhat successful in increasing native American nurses and technicians, much more needs to be done. Perhaps mentorship or apprenticeship programs for junior high and high school students could be initiated. Additional assistance in reading, mathematics and science is also needed.

While the proposed loan repayment program provides an educational incentive for non-native students of nursing, and to those native Americans who attend schools of nursing off the reservation, it does not address the need of those native Americans who choose to pursue their education and training through tribal colleges. These students have found that Guaranteed Student Loans (GSL) are not applicable to degrees sought through a tribal college. Because an alarming percentage (we have been told it may be as high as 90%) of those students who attend college off the reservation return without having completed their degrees, nursing programs coordinated through tribal colleges may prove to be a very successful means of educating and preparing native American nurses. Therefore, it seems appropriate to consider alternatives to the GSL criteria to accommodate those students planning to attend tribal colleges, or to provide specific funds as loans or stipends for them. In light of the ever pressing problem of nurse recruitment and retention, as it exists in the IHS today, funding for purposes of nursing education is clearly warranted.

Mr. Chairman, we believe this hearing represents a solid commitment to improve nurse recruitment and retention within IHS and to thereby improve the health status of the American Indian and Alaska native. ANA looks forward to working with the committee to secure the passage of this legislation.

# STATEMENT

of

# THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

on

# S. 1475 AND CLINICAL STAFFING SHORTAGES IN THE INDIAN HEALTH SERVICE

Presented by

**Loren Petersen, M.D., FACOG**

before the

Select Committee on Indian Affairs

United States Senate

**August 6, 1987**

Mr. Chairman and members of the Committee, my name is Loren Petersen, M.D. I am an obstetrician-gynecologist from Yankton, South Dakota and Chairman of the Committee on American Indian Affairs of the American College of Obstetricians and Gynecologists (ACOG). I am pleased to have this opportunity to testify on behalf of ACOG in support of establishing a loan repayment program that will help assure the Indian Health Service (IHS) of an adequate supply of clinical personnel.

The ACOG is an organization dedicated to the promotion of high quality health care for women and their infants. Since 1970 the ACOG Committee on American Indian Affairs has served in an advisory capacity to the IHS, reviewing the quality of maternal and child health care delivered by the IHS. To accomplish this, the Committee has visited virtually every IHS service area and the 14 IHS hospitals which provide complete obstetric care to observe first-hand the provision of health care to mothers and infants. Observations and recommendations of the Committee are documented in a report which is sent to the IHS after each site visit.

The ACOG also cooperates with the IHS in sponsoring a postgraduate course designed to meet the continuing education needs of physicians, nurse-midwives, nurses, and other health professionals caring for women and infants in IHS settings. Since 1980 we have sponsored seven courses which have enrolled a total of approximately 700 physicians and nurses and are now making plans for a course to be held this fall covering topics such as prenatal care, complications of pregnancy, and perinatal infections.

Finally, the College sponsors a volunteer program called ACOG Fellows in Service to Native American Women. Originally established in 1979, this program arranges for Fellows who are in private practice to leave their practices for one month or more and volunteer their services in IHS hospitals. ACOG volunteer physicians have been received enthusiastically by health care professionals already working within the IHS. It is reported that they improve morale by alleviating staffing shortages and providing opportunity for educational exchange. To date, ACOG has placed approximately 100 physician volunteers, some of whom have volunteered more than once, in eight IHS service units located in Oklahoma, Arizona, and New Mexico. In 1987 the program has been expanded to include hospitals in Alaska and South Dakota, bringing to 14 the IHS hospitals eligible for ob-gyn volunteers. Since May 1987 when the expanded program began, ACOG has agreed to supply volunteers to serve up to 90 physician weeks, as they are requested. Of these, 21 weeks of volunteer service are currently scheduled.

The volunteer program is important for recruitment and retention of obstetrician-gynecologists for several reasons. First of all, volunteers provide direct services to patients when the usual recruitment and retention system breaks down, allowing for uninterrupted patient care when staffing vacancies occur. Additionally, the availability of volunteers for coverage so that IHS physicians can take vacations or pursue continuing medical education is a very positive factor in the recruitment and retention of IHS specialists; one obstetrician-gynecologist has specifically said he would not have completed his term without this assistance. A more subtle value may be the relief from isolation and the sense of positive support and recognition from the private sector that the program contributes. A few individuals have used the ACOG volunteer program as an opportunity to try out service in the IHS before signing on with the service as a regular employee.

Recruitment and retention of obstetrician-gynecologists and of clinical support staff have been a key concern of the College since our earliest involvement with the IHS. Direct recruitment of obstetrician-gynecologists has largely occurred through various programs requiring a service payback for education. In recent years the National Health Service Corps (NHSC) has been the major source through which IHS vacancies have been filled, accounting for 130 to 150 IHS placements annually. Of the 37 obstetrician-gynecologists employed by the IHS, approximately 30 are current or former NHSC recipients.

The ACOG has urged that preference be given to assigning obstetrician-gynecologists in the NHSC to the Indian Health Service, based on our Committee's assessment of the need. The ACOG has also informed its Junior Fellows by direct mail, pointing out the needs of the IHS and urging those with a service obligation to consider the IHS option. For the most part, during recent years, IHS has been able to fill its positions for obstetrician-gynecologists. Unexpected shortfalls, ranging from a few weeks to a year in one case, have been filled by ACOG short-term volunteers.

Because of its reliance upon the NHSC and as a result of the dramatic decline in the number of NHSC physicians expected to be available after 1988, the ACOG has serious concerns about a potentially severe manpower shortage within the IHS. It must be emphasized that IHS has to overcome tremendous obstacles in order to recruit physicians willing to serve at IHS facilities. Rural isolation, inadequate medical facilities and housing, and understaffing are characteristic of many IHS services sites.

I can best illustrate this point by describing the IHS service sites with which I am most familiar, having worked in the Aberdeen area for the past ten years. In October 1983, the College's then-Task Force on American Indian Affairs visited the Rosebud and Eagle

Butte reservations in South Dakota to assess the quality of maternal and child health care in the Aberdeen area. Members of the Task Force were shocked by the extreme rural isolation of the Rosebud and Eagle Butte communities. To reach adequate tertiary care facilities necessitates an hour and a half of flying time or a four hour drive by ambulance. Emergency cases are transported out by air, but airstrips at both Rosebud and Eagle Butte lack two-way communication systems and lights for night arrivals and departures. In fact, the airstrip at Eagle Butte is located in a pasture, on a hillside. These communities are totally inaccessible by air during snow storms.

The administrative offices of the Rosebud facility, which were built in 1911, have been condemned but are still in use. Insect infestation and erosion from water damage are evident. There is no obstetrician at either Rosebud or Eagle Butte. Nor are there any surgical, pediatric, or other speciality services available. The University of South Dakota Department of Obstetrics and Gynecology sends a resident to Eagle Butte and Rosebud once a week to see high-risk patients and screen for high-risk pregnancies. Both units have a large incidence of high-risk patients who require transfer for delivery to a tertiary care center, at a cost of approximately $750 per patient.

Pine Ridge Reservation, also in South Dakota, currently has only one obstetrician-gynecologist on staff, who, with the assistance of a resident, has performed over 350 major surgical procedures and has been responsible for more than 400 deliveries during the past year. In order to provide him relief until another physician can be hired, ACOG is attempting to supply volunteers through the summer and fall of 1987.

Besides rural isolation, inadequate facilities and housing, and understaffing, IHS physician salaries are low compared to those in the private sector and are a further disincentive to voluntary recruitment. For these reasons the College is convinced that not even the most effective voluntary recruitment program will enable the IHS to meet all of its manpower needs. A service payback or loan repayment program is therefore essential for successful physician recruitment by the IHS for the foreseeable future.

S. 1475 would establish a loan repayment program in which the Secretary of Health and Human Services would contract with qualified applicants for repayment of up to $25,000 in principal, interest, and related expenses per year of obligated service on government and commercial loans received by the individual for tuition and other expenses. There would be a minimum period of two years of obligated service.

The loan repayment program established in this bill, and a similar program established in S. 1158 which was recently passed by the full Senate, offer the IHS several distinct advantages. One advantage is that only those individuals who possess the specific speciality or clinical training most needed by the IHS would be recruited. Additionally, there would be an immediate return on the federal dollars invested in the program because these individuals would be selected at the completion of their training as they are ready to begin clinical practice. Thus, the IHS would be able to select and recruit according to its immediate personnel needs.

In addition to aiding in physician recruitment, the College supports inclusion of loan repayment for nurses and other health professionals as in the bill. Nursing and other support services are frequently the limiting factor regarding the care that can be given obstetric, gynecologic, and neonatal patients at a particular IHS location. The ACOG's site visits confirm that nursing services are understaffed and many lack the special training needed to care for patients in labor, delivery and the neonatal nursery.

The College supports the use of nurse-midwives and nurse practitioners with special skills related to maternal and child health and gynecologic care to serve coordinating functions and to institute health promotion and disease prevention activities in the community, in addition to roles they may fill in the hospital setting. Community health representatives are also used to provide health and nutrition education to pregnant women and to motivate them to seek prenatal care. Pregnant women who are remote from IHS facilities would often go without prenatal care if it were not for these home visits.

In conclusion, the ACOG applauds Senator Melcher and Senators Inouye and Burdick for introducing S. 1475 and the Select Committee on Indian Affairs for holding this hearing. A loan repayment program is an important and necessary step. It is an excellent means for assuring the continued viability of the Indian Health Service.

# STATEMENT

of the

# AMERICAN MEDICAL ASSOCIATION

to the

Senate Select Committee on Indian Affairs

RE: S. 1475, Indian Health Service Clinical Staffing
Recruitment and Retention Program

August 6, 1987

The American Medical Association has long supported the Indian Health Service (IHS) in carrying out its statutory authority "to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level." We believe that S. 1475, a bill to establish an effective clinical staffing recruitment and retention program for the IHS, would greatly enhance the likelihood that this purpose can be fulfilled.

## Background

The IHS deserves to be commended for its many successes. Due primarily to IHS efforts, the maternal mortality rate for American Indians and Alaska Natives residing in reservation states, according to the IHS, dropped a dramatic 89% between 1957 and 1983. The infant mortality rate for these same Native Americans dropped 82% between 1954 and 1981.

Even with this level of achievement, however, the work of the IHS must continue. Again according to the IHS, the age-adjusted mortality rates for a variety of health or health-related problems of Indians living in reservation states in 1983 were startlingly higher than for the general U.S. population. The mortality rate for tuberculosis was 560 percent greater; for diabetes mellitus, 107 percent greater; for homicides, 91 percent greater; and for pneumonia and influenza, 39 percent greater.

## Clinical Staffing Shortages

These statistics only add to an already heightened sense of urgency resulting from the projections of shortfalls of physicians and other health care professionals recently documented by the Office of Technology Assessment (OTA) in its special report entitled "Clinical Staffing in the Indian Health Service." According to the report, the IHS will need 200 new physicians annually between 1987 and 1993. While the National Health Service Corps (NHSC) currently provides the IHS with between 130 and 150 physicians each year, Congress has yet to reauthorize the NHSC field placement program. Without reauthorization, this resource of physicians will diminish quickly after 1988 when current authorization ends.

Even with better retention of staff and more aggressive recruiting, as the OTA report recommends, it is clear that the IHS will not be able to meet its manpower needs solely on a voluntary basis. The disincentives of low pay and extremely isolated locations make it unlikely that enough physicians will be able to make the sacrifices necessary to fill all IHS positions. While it is thought that a possible surplus of physicians in the near future will act as an economic inducement to encourage more physicians into IHS practices — a scenario the OTA rejects -- it is certain that young physicians are entering medicine with increasingly higher education debts. Fewer physicians will be able to afford to practice with the IHS.

Encouraging Physician Participation

However, we know that the interest among physicians to provide the necessary medical services to Native Americans is strong. Since 1973, the AMA has administered Project USA, a program coordinated with the NHSC and the IHS to recruit physicians for medically underserved Indian communities and rural areas. Through Project USA, a steady supply of physicians have accepted appointment with the NHSC or the IHS and have volunteered as short-term replacements for physicians serving in the U.S. Public Health Service in Indian communities and other rural locations.

It is this kind of genuine interest among physicians that will be broadened with the loan repayment program and other incentives proposed in S. 1475. The current mechanism for encouraging participation by physicians and other health care professionals in the NHSC, the NHSC Scholarship Program, is not effective. Medical students accept NHSC scholarships early in their medical education when they have a great need for money but little idea of the lifestyles or the medical practices they will want to establish upon graduation. It has proven to be unrealistic to expect these individuals, and the families they often gain in the meantime, to then effectively serve in isolated areas and in practices for which they have little interest. The high default rate and ensuing litigation surrounding the NHSC Scholarship Program bear witness to its impracticality.

The loan repayment program proposed in S. 1475 should be much more effective. Medical students at the end of their education or practicing physicians will be able to commit themselves to an IHS practice at the time they are willing to accept placement, thereby allowing personal responsibilities and medical practice interests to be taken into consideration. Administration of such a program would also make more sense since actual manpower needs could be met on a selective basis with a short lead time. The participants would most certainly be highly motivated, increasing greatly the likelihood of retaining physicians in the IHS. The OTA report also supports this approach, suggesting that such a program "could well be less costly and more effective than continuation of the NHSC scholarships."

Other incentives contained in S. 1475 also should help improve clinical staff recruitment for the IHS. Special incentive pay for persons willing to work in positions where recruitment or retention is difficult and retention bonuses to encourage long-term service are excellent ideas. Expanded recruitment efforts should also prove helpful, including recruitment at health profession schools, grants to Indian tribes to test their own innovative techniques to recruit and retain clinical staff, and, as the OTA special report suggested, allowing reimbursement of travel expenses for spouses of health professionals when they visit potential placement sites. The programs that will allow flexible work schedules, provide instruction on tribal culture and history, and enable health professionals to pursue advanced training or conduct research should all help to improve clinical staff retention rates.

## Foreign Medical Graduate Demonstration Project

One provision of S. 1475 would establish a three-year demonstration project to train foreign medical graduates to obtain licenses as physician assistants. Physicians assistants can be used effectively to expand the delivery of health services. However, this program should not be viewed as an alternative to meeting the need for physicians. Native Americans deserve the highest level of medical care, and the emphasis of this bill should remain on alleviating physician shortages. Notwithstanding, the provision under discussion will provide voluntary alternatives for foreign medical graduates, and this proposal, as a demonstration project, should be monitored closely.

## Conclusion

S. 1475 appropriately addresses projected shortfalls of physicians and other clinical staff in the IHS. The AMA's years of experience recruiting physicians for the IHS through Project USA tells us that physicians have a strong and constant interest in providing needed medical care to Native Americans. The programs contained in S. 1475 have the potential to encourage and expand that interest. We urge Congress to quickly pass this bill into law.

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August 3, 1987

The Honorable Daniel K. Inouye
Chairman, Select Committee on Indian Affairs
722 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Inouye:

This letter is being submitted for the record of the hearing held before the Select Committee on Indian Affairs, August 6, 1987, on the Indian Health Service Loan Repayment Program.

The American Academy of Pediatrics has had an active and longstanding commitment to improving the health status of Native American children. The Academy's Subcommittee on Indian Health recently made site visits to three service units in the Aberdeen area to meet with Indian Health Service staff to discuss pediatric care. The site visits confirmed the existence of the physician manpower crisis within the Indian Health Service. The implementation of comprehensive well child care programs has been hampered as the dwindling supply of pediatricians struggle to meet acute health care needs.

Recruitment and retention of qualified pediatricians to these remote, isolated areas has always been a challenge. The termination of the National Health Service Corp Scholarship program has eliminated the only reliable source of clinical staff and has created an urgent demand for new recruitment strategies. The Academy strongly supports the establishment of a loan repayment program in order to increase the supply of pediatricians for the Indian Health Service. Enabling the Indian Health Service to repay educational loans for pediatricians in exchange for their services is a practical solution to this critical problem.

Your efforts to enable Native American children to receive high quality care from well-trained pediatricians are greatly appreciated.

Sincerely yours,

William C Montgomery MD

William C. Montgomery, M.D.
President

WCM/esb